92-315

No. _____

Supreme Court, U.S.
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IN THE

Supreme Court of the United States

OCTOBER TERM, 1992

CESAR A. PERALES, as Commissioner of Social Services of the State of New York,

Petitioner,

—v—

NEW YORK CITY HEALTH AND HOSPITALS CORPORATION; MEDICAL SOCIETY OF THE STATE OF NEW YORK; SIDNEY FINKEL, JOHN A. BLESKI, and LOUIS W. SULLIVAN, as Secretary of the United States Department of Health and Human Services,

Respondents.

PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SECOND CIRCUIT

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QUESTION PRESENTED

May a State limit Medicaid reimbursement to the Medicaid rate of payment for services rendered to Medicaid recipients enrolled by the State in the Medicare program?

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IN THE

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OCTOBER TERM, 1992

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CESAR A. PERALES, as Commissioner of Social Services of the State of New York,

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NEW YORK CITY HEALTH AND HOSPITALS CORPORATION; MEDICAL SOCIETY OF THE STATE OF NEW YORK; SIDNEY FINKEL, JOHN A. BLESKI, and LOUIS W. SULLIVAN, as Secretary of the United States Department of Health and Human Services,

Respondents.

PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SECOND CIRCUIT

The Commissioner of Social Services of the State of New York petitions for a writ of certiorari to review the judgment of the United States Court of Appeals for the Second Circuit.

OPINIONS BELOW

The opinion of the Court of Appeals (Appendix, *infra*, 1a-34a) is reported at 954 F.2d 854 (2d Cir. 1992). The opinion of the District Court (Appendix, *infra*, 35a-48a) is unreported.

JURISDICTION

The judgment of the Court of Appeals was entered on February 3, 1992. Rehearing was denied on May 20, 1992. (Appendix, *infra*, 49a). The jurisdiction of this Court is invoked under 28 U.S.C. § 1254(1).

STATUTES AND REGULATION INVOLVED

The New York State Medicaid regulation challenged in this case, 18 New York Code, Rules and Regulations ("N.Y.C.R.R.") § 360-7.7 (1989) (formerly codified at 18 N.Y.C.R.R. § 360.10) and the relevant provisions of the federal Medicare and Medicaid Acts, specifically, 42 U.S.C. §§ 1395cc(a)(2)(A), 1396a(a)(10)(E)(i), 1396a(n) and former § 1396a(a)(15), respectively, are reproduced in the Appendix (*infra*, 50a-55a).

STATEMENT

This case involves a challenge under the Medicare and Medicaid statutes, Titles XVIII and XIX of the Social Security Act, 42 U.S.C. §§ 1395-1395ccc and §§ 1396 *et seq.*, respectively, to a New York State Medicaid regulation (18 NYCRR § 360-7.7) that was approved by the Secretary of the United States Health and Human Services (the "Secretary"). The challenged regulation limits Medicaid reimbursement to the Medicaid-approved rate for those providing medical services to persons who are eligible under both Medicaid and Medicare. These individuals are sometimes referred to as "dual-eligible" or "cross-over" beneficiaries.

Medicaid is a joint federal and state program providing medical care to poor persons. 42 U.S.C. § 1396 *et seq.* Individual states administer the Medicaid program pursuant to a state plan approved by the Secretary. 42 U.S.C. § 1396a. The state plan must include, among other things, a schedule of payment for the medical services covered by the program. 42 U.S.C. § 1396a(a)(13). The federal government reimburses

the states for a portion of their Medicaid expenditures, which for New York is 50 percent. 42 U.S.C. § 1396*b*. The Medicaid program reimburses those providing services to Medicaid recipients at the Medicaid-approved rate of payment, but only after any "third party" insurance coverage has been exhausted. 42 U.S.C. § 1396a(a)(25). Providers participating in the Medicaid program must accept as payment in full the Medicaid rate of payment, and may not charge in excess of that amount. 42 U.S.C. § 1396h(d); 42 C.F.R. § 447.15.

Medicare is exclusively a federally funded and administered program providing health insurance to the elderly and certain disabled persons. 42 U.S.C. §§ 1395 *et seq*. The Medicare program is composed of two parts: Part A provides insurance for hospital care, and Part B provides supplemental insurance for physician and other health services. 42 U.S.C. §§ 1395c–1395*i*-4 and 1395j–1395w-4. Part A coverage is provided by the federal government to all Medicare-eligible persons, while Part B is voluntary coverage which may be purchased.

Those eligible for Medicare Part B can enroll in the program by paying monthly premiums. 42 U.S.C. § 1395r. The Medicare program pays 80% of the approved charge or reasonable charge established by the Secretary for a given service (after the beneficiary has paid the annual deductible), and the beneficiary is responsible for paying the remaining 20% as a co-payment. Section 1395*l*(a)(1). Physicians in the Medicare program must accept as payment in full the Medicare approved charge or reasonable charge for a given service. 42 U.S.C. § 1395u(b)(3)–(B)(ii). The physician submits a claim to Medicare and is reimbursed for 80% of the charge. The physician then may charge the Medicare-only beneficiary for the co-payment. 42 U.S.C. § 1395cc(a)(2)(A).

Under the Medicare Act, states can enroll their dual-eligible beneficiaries in Medicare by paying the Medicare premiums on their behalf. 42 U.S.C. § 1395v; 42 CFR § 407.40–407.50. In essence, these "buy in" agreements allow the states to purchase Medicare coverage as "third party"

insurance for their Medicare-eligible Medicaid recipients. Such recipients would not otherwise be covered by Medicare Part B.

In 1986, Congress amended the Medicaid statute to authorize states also to enroll in Medicare a category of beneficiaries referred to as "qualified Medicare beneficiaries" ("QMBS"). 42 U.S.C. § 1396a(a)(10)(E)(i). QMBs now include Medicaid-eligible as well as the "near poor", *i.e.*, those whose income is equal to or less than 100% of the federal poverty level, whose resources do not exceed twice the eligibility level for Supplemental Security Income ("SSI") under 42 U.S.C. § 1382a, and who are entitled to Medicare Part A coverage. 42 U.S.C. § 1396d(p)(3). With respect to the amounts to be paid by the states for QMBs enrolled in Medicare, the Medicaid Act permits, but does not require, the states to pay Medicare "cost-sharing" amounts for QMBs (deductibles and co-payments) that result in payments in excess of Medicaid rates. 42 U.S.C. § 1396a(n).

Under the Secretary's interpretation of the Medicaid Act, a state "is not necessarily obligated to pay the full amount of the deductibles and coinsurance costs according to the rates established under Title XVIII [Medicare], but only that amount which will satisfy the requirement for payment in full according to the Title XIX [Medicaid] method of payment." *See* Memorandum dated January 10, 1986, from Richard P. Kisserow, Inspector General, Department of Health and Human Services, to C. McClain Haddow, Health Care Financing Administration. Prior to 1987, however, New York State's Medicaid program provided for reimbursement of all cost sharing amounts. To contain Medicaid costs, the Secretary encouraged states like New York to limit Medicaid reimbursement for cost-sharing amounts to the Medicaid rate. Accordingly, New York, in 1987, submitted a Medicaid plan amendment to incorporate the challenged regulation in its

State plan. On March 16, 1988, the Secretary approved the amendment.[1]

Under the New York regulation, effective in 1987, the Medicaid program in New York State would reimburse providers for the 20% Medicare co-payment up to the Medicaid rate, provided the amount paid by Medicare did not equal or exceed the Medicaid rate. 18 NYCRR § 360-7.7(a)-(b). New York would continue to pay the premiums of dual-eligible beneficiaries and providers would continue to receive a higher level of reimbursement than the Medicaid rate to the extent that the Medicare 80% payment exceeded the Medicaid rate.

Thus, under the New York regulation, Medicaid would provide the same amount of reimbursement to medical providers regardless of whether the patients they have treated are Medicaid-eligible only or are dual-eligible beneficiaries. As with Medicaid only recipients, providers are prohibited from looking to dual-eligible beneficiaries for any payment. Since the Medicare payment is often higher than the Medicaid-approved rate, however, these providers often would receive higher reimbursement when the patient is a dual-eligible beneficiary.

On July 8, 1987, respondents (other than the Secretary) commenced this action, pursuant to 42 U.S.C. § 1983, in the U.S. District Court for the Southern District of New York against petitioner and respondent Secretary. Respondents sought declaratory and injunctive relief on the ground that the challenged regulation violates the Medicare and Medicaid Acts because it does not allow providers to recover, in addition to the Medicare payment, the full amount of the 20% co-payment for dual-eligible beneficiaries, without limitation to the Medicaid-approved rate.

The parties cross moved for summary judgment. In an opinion and order dated March 18, 1991, the district court

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1 Upon information and belief, approximately 30 other states have adopted limitations on Medicaid reimbursement similar to the challenged regulation.

(Lowe, D.J.) granted petitioner's and the Secretary's motions. The court found that the Secretary's approval of the challenged regulation was based upon a rational interpretation of complex and ambiguous statutes.

In effect at the time that the case was briefed in the District Court was the predecessor to 42 U.S.C. § 1396a(a)(10)(E), former section 1396a(a)(15). (Appendix, *infra*, 55a) The Secretary interpreted this provision as regulating the payment of cost-sharing amounts only when, under a state's plan, the provider is allowed to collect some portion of the cost-sharing amount from the dual-eligible beneficiary. In that circumstance, the state plan must take into account the beneficiary's "income or his income and resources." Respondents, on the other hand, interpreted this provision as requiring the state plan to provide for payment in full of all cost-sharing amounts, less any portion imposed upon the beneficiary determined in accordance with the beneficiary's means.

The District Court held that under *Chevron U.S.A. v. Natural Resources Defense Council*, 467 U.S. 837, 842-43 (1984),[2] the Secretary's interpretation was entitled to deference and should be upheld. On April 29, 1991, the District Court entered a final judgment in favor of petitioner and the Secretary.

On appeal, a divided Court of Appeals for the Second Circuit reversed the judgment below and annulled the challenged regulation. (Appendix, *infra*, 1a-34a) The majority opinion found that the Secretary's approval of the challenged regulation was inconsistent with the Medicare Act and the "buy in" provisions in the Medicaid Act. (*Id.*, 1a-20a) The major-

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2 *Chevron* holds that when "the statute is silent or ambiguous with respect to the specific issue, the question for the court is whether the agency's answer is based on a permissible construction of the statute." 467 U.S. at 843. The agency's interpretation is permissible and must be upheld so long as it is not "manifestly contrary" to the statute. *Id.*, at 845.

ity specifically interpreted 42 U.S.C. § 1395cc(a)(2)(A),[3] as granting the provider a right to collect the 20% co-payment whenever payment is made under Medicare Part B, even when the patient is a dual-eligible beneficiary. (*Id.*, 9a) The Court of Appeals thus held that the New York State Medicaid program is required to pay the full 20% co-payment of dual-eligible beneficiaries, without limitation to the Medicaid rate. (*Id.*, 10a-11a)

In dissent, Judge Cardamone noted that neither the Medicare and Medicaid Acts nor the relevant legislative history express an intent on the part of Congress to require states under "buy in" agreements to reimburse providers without limitation up to the Medicare charge level. Like the district court, Judge Cardamone concluded that under *Chevron* and other precedents of this Court, the Secretary's interpretation of the statutes was reasonable, and was entitled to deference.[4] (Appendix, *infra*, 31a-34a).

REASONS FOR GRANTING THE PETITION

In 1988, the Secretary approved New York's regulation to limit Medicaid reimbursement for dual-eligible beneficiaries to the Medicaid rate. At the present time, upon information and belief, the Secretary has approved approximately 30 other similar state regulations. Although the Second Circuit's decision is the only decision by an appellate court to construe the validity of the Secretary's policy on dual-eligibles, the decision should be reviewed now for four reasons: first, the

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3 This section provides that the physician in the Medicare program "may charge" the 20% co-payment, but does not specifically provide that the physician has the right to collect the 20% co-payment when he has treated a Medicaid-eligible patient enrolled in Medicare by the State under a "buy in" agreement.

4 It is estimated that this requirement will cost the Medicaid program in New York State more than $50 million annually. Moreover, the provider respondents have communicated their intention to commence litigation in state court and will try to use the Court of Appeals' opinion collaterally against the State to obtain millions of dollars in retroactive relief through 1987, when the challenged regulation was adopted.

decision has national significance because of the existence of similar regulations in a majority of the states (*see Simon & Schuster v. Members of the New York State Crime Victims Board*, ____ U.S. ____, 112 S.Ct. 501, 508 [1991]); second, the decision involves a significant and unresolved issue of statutory and regulatory interpretation involving the interplay between the Medicaid and Medicare Acts as applied to dual-eligible beneficiaries; third, the majority and dissenting opinions of the Second Circuit contain a comprehensive analysis of the distinct legal positions that would be presented in this Court by the parties; and fourth, the Second Circuit's decision has immediate and drastic fiscal consequences for New York which already is facing severe budgetary constraints.

Review of the Court of Appeals' decision will provide this Court with the opportunity to further define the *Chevron* standard. The majority opinion relied principally upon its interpretation of section 1395cc(a)(2)(A) of the *Medicare* Act and legislative history applicable primarily to Medicare Part A in refusing to adopt the Secretary's interpretation, and in reaching the conclusion that the provider has a right to collect 100% of the Medicare charge level even when treating a dual-eligible beneficiary.

The dissent and the District Court, on the other hand, noted the absence of express language in this section or elsewhere in the Act supporting such a conclusion. Faced with an ambiguous and, as the majority opinion acknowledged, "a complicated statutory scheme,"[5] they followed the reasoning in *Chevron* and deferred to the Secretary's interpretation.

The Secretary's interpretation is supported by language in the *Medicaid* Act, which provides that states enrolling QMBs in Medicare "may", but are not required, to pay Medicare co-payments and deductibles, in excess of the Medicaid rate.

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5 This Court has similarly observed that the "Social Security Act is among the most intricate drafted by Congress. Its Byzantine construction, as Judge Friendly observed, makes the Act 'almost unintelligible to the uninitiated.' " *Schweiker* v. *Gray Panthers*, 453 U.S. 34, 43 (1981) (quoting from *Friedman* v. *Berger*, 547 F.2d 724, 727 n.7 [2d Cir. 1976], *cert. denied*, 430 U.S. 984 [1977]).

42 U.S.C. § 1396a(n). *See Farmers Merchants Bank of Monroe, N.C.* v. *Federal Reserve Bank*, 262 U.S. 649, 662 (1923) ("may" ordinarily connotes discretion). In contrast to the section of the Medicare Act relied upon in the majority opinion (42 U.S.C. § 1395cc[a][2][A]), which deals generally with physicians' charges to Medicare beneficiaries, this section of the Medicaid Act deals specifically with payment for services to QMBs enrolled by the states in Medicare. *See Busic* v. *United States*, 446 U.S. 398, 406 (1980) ("a more specific statute will be given precedence over a more general one.").

In rejecting the Secretary's interpretation of the Medicaid and Medicare Acts, the majority opinion erroneously failed to apply the principle of deference to the Secretary's construction of complex Medicaid and Medicare statutes, *see e.g.*, *Chevron USA Inc. v. National Resources Defense Council, Inc.*, 467 U.S. 837, 843 (1984); *Morton v. Ruiz*, 415 U.S. 199, 231 (1974). The majority refused to defer to the Secretary's interpretation, based on its reasoning that the general provision in the Medicare Act, that providers may collect their reasonable costs or charges, contains no exception for dual-eligible beneficiaries, and that therefore New York's regulation "appears, on its face, to violate the Medicare Act." (Appendix, *infra*, 10a). However, as the dissenting opinion points out, the delegation of agency authority may be implicit rather than explicit and nothing in the relevant statutes fairly supports the conclusion that Congress specifically intended providers of dual-eligible beneficiaries to be reimbursed at the full Medicare reasonable cost/charge standard. (Appendix, *infra*, 22a)

The Secretary's position, that dual-eligible beneficiaries are "primarily Medicaid patients" and that state plans need only provide reimbursement for these patients in conformance with the standards in the Medicaid Act, is not only reasonable but is supported by the legislative history, as the dissenting opinion points out. The relevant legislative history demonstrates that Congress desired to ensure full reasonable cost/charge reimbursement only under Medicare Part A, and that Congress did not necessarily assume the same standard

of reimbursement for dual-eligible beneficiaries under the voluntary elective Part B program. *See* S. Rep., No. 404, 89th Cong., 1st Sess., *reprinted in* 1965 U.S. Code Cong. & Admin. News 1943, 1964-2011. (Appendix, *infra*, 26a-27a) (dissenting opinion below). The Senate Report distinguishes between Part A and Part B payment by the states, and with respect to Part B, states that "[a] State medical assistance plan *may* provide for the payment in full of any deductibles or cost sharing under [Part B]. *Id.* at 2019-2020 (emphasis added) (Appendix, *infra*, 30a) (dissenting opinion).

The majority's opinion also ignores provisions and objectives of the Medicaid Act which are more applicable to dual-eligible beneficiaries than are the ambiguous provisions of the Medicare Act. The objective of the Medicaid program is, "*as far as practicable*, to furnish medical assistance to individuals whose income and resources are insufficient to meet the costs of necessary medical services." *Beal v. Doe*, 432 U.S. 438, 444 (1977) (emphasis added). Congress granted the states the authority to administer the Medicaid program under this broad directive, and the states' determinations on how to fund their programs need only accord with "reasonable standards . . . for determining . . . the extent of medical assistance under [its] plan . . . which are consistent with the objectives" of the Medicaid Act. *Id.*, at 441 (quoting from 42 U.S.C. § 1396a[a][17]). The Second Circuit's decision thus interferes with New York's broad statutory authority to determine rates of payment in conformance with the Medicaid Act.

Moreover, the majority opinion, in contrast to the dissent and the District Court, appears to treat all dual-eligible beneficiaries as if they are like all other Medicare patients, and their providers, like all other Medicare providers. It is undisputed that providers may not collect more than the Medicaid rate of payment when treating Medicaid-only recipients. 42 U.S.C. § 1396h(d). Medicaid recipients, when also eligible for Medicare, remain Medicaid recipients states and indeed are only enrolled in the Medicare program by the states by virtue of their status as Medicaid recipients. Part B Medicare cover-

age, when purchased by the states for dual-eligible beneficiaries, is no different from any other kind of "third party" insurance coverage which must be exhausted before Medicaid will pay the provider up to the Medicaid rate.

The majority opinion's holding—recognizing in providers a right to collect the full amount of the co-payment, in excess of the Medicaid rate, for services rendered to all dual-eligible beneficiaries—cannot be reconciled with the reality that the beneficiaries the providers are treating are primarily Medicaid patients. Furthermore, it grants providers an unjustified windfall of higher reimbursement for having treated dual-eligible beneficiaries, solely by virtue of the fact that the State has enrolled them in the Medicare program. The Court of Appeals' decision creates the anomaly of a two-tiered, unequal Medicaid reimbursement scheme, one for Medicaid-eligible only, and another higher level for Medicaid-eligible who also happen to be Medicare-eligible.

Finally, the Court of Appeals' opinion means that New York State must now pay providers the full 20% co-payment for services to all dual eligible beneficiaries, without limitation to the Medicaid rate. As noted earlier, this requirement will cost the State millions of dollars annually, and may result in retroactive payment in the millions of dollars, as well. The issue is of great importance to many other states, as some thirty other states throughout the country have adopted Medicaid regulations that similarly limit Medicaid reimbursement. Unless this issue is resolved by this Court now, these states face the prospect of judicial challenges in reliance upon the Second Circuit's opinion, putting into jeopardy their Medicaid programs and their multi-million-dollar budgets.[6] Resolution of this issue by this Court now will eliminate this uncertainty and, if favorable to petitioner, will reinstate and preserve an enormous cost savings to the Medicaid program in New York State and in many other states.

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6 Upon information and belief, two such challenges have already been brought in Pennsylvania and Alabama.

CONCLUSION

The petition for a writ of certiorari should be granted.

Dated: New York, New York
August 18, 1992

Respectfully submitted,

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UNITED STATES COURT OF APPEALS

FOR THE SECOND CIRCUIT

No. 142—August Term 1991

Argued: August 28, 1991 Decided: February 3, 1992

Docket No. 91-6123

NEW YORK CITY HEALTH AND HOSPITALS CORPORATION; MEDICAL SOCIETY OF THE STATE OF NEW YORK; SIDNEY FINKEL and JOHN A. BLESKI,

Plaintiffs-Appellants,

—against—

CESAR A. PERALES, as Commissioner of Social Services of the State of New York and LOUIS W. SULLIVAN, M.D., as Secretary of the United States Department of Health and Human Services,

Defendants-Appellees.

Before:

OAKES, *Chief Judge*,
FEINBERG and CARDAMONE, *Circuit Judges*.

Appeal from order and judgment of dismissal by the United States District Court for the Southern District of New York, Mary Johnson Lowe, J. Plaintiffs contend that the district court erred in upholding a New York regula-

tion, 18 NYCRR 360.10, under the Medicare and Medicaid Acts.

Reversed. Judge Cardamone dissents in a separate opinion.

PETER F. NADEL, New York, NY (Rosenman & Colin, Joseph V. Willey, of Counsel; LeBoeuf, Lamb, Leiby & MacRae, New York, NY, Jay G. Safer, Ronald J. Gizzi, of Counsel), *for Plaintiffs-Appellants*.

KAY K. GARDINER, New York, NY, Assistant United States Attorney for the Southern District of New York, Otto G. Obermaier, United States Attorney for the Southern District of New York, Marla Alhadeff, Assistant United States Attorney, of Counsel), *for Defendant-Appellee Sullivan*.

FEINBERG, *Circuit Judge*:

This case involves a challenge to New York State's elimination of the rights of health care providers to receive reasonable compensation when they treat poor Medicare patients. Plaintiff-appellant New York City Health and Hospitals Corporation is a New York public benefit corporation created by New York State. It is a principal provider of hospital services to the low-income population of the City. Plaintiff-Appellant Medical Society of the State of New York, the largest voluntary association of physicians in New York, is a non-profit

corporation organized and existing under the laws of New York State. Plaintiffs-appellants Sidney Finkel, M.D. and John A. Bleski, M.D. are physicians who participate in the Medicare program; many of their patients are eligible under both Medicare and Medicaid. Defendant-appellee Cesar A. Perales is the New York State Commissioner of Social Services. Defendant-appellee Louis W. Sullivan, M.D., is Secretary of the United States Department of Health and Human Services (the Secretary). Perales concurs with the views of Sullivan as set out in his brief.

Appellants appeal from a judgment of the United States District Court for the Southern District of New York, Mary Johnson Lowe, J., dismissing plaintiffs' complaint challenging a regulation of the New York State Department of Social Services as violative of the Medicare Act, Title XVIII of the Social Security Act, 42 U.S.C. §§ 1395-1395ccc, and the Medicaid Act, Title XIX of the Social Security Act, 42 U.S.C. §§ 1396, et seq. The Medicare program provides funds that help subsidize medical care for the elderly and for certain disabled individuals. The Medicaid program subsidizes medical assistance for the poor.

Appellants claim that the regulation at issue, N.Y. Comp. Codes R. & Regs. tit. 18, § 360.10 (1988),[1] which has been approved by the Secretary, violates the Medicare and Medicaid Acts. For the reasons given below, we agree. Accordingly, we reverse and remand with directions to grant summary judgment for appellants.

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1 Effective March 1, 1989, 18 NYCRR § 360.10 was repealed and recodified as 18 NYCRR § 360-7.7. For purposes of consistency, the regulation will be referred to as "the Regulation."

I. Introduction

Before addressing the merits of the controversy before us, it is important that we clarify various terms of the relevant statutes. Under the Medicare Act, the federal government provides people who are 65 years of age and older and certain disabled individuals (people who are Medicare-eligible) with an inpatient hospital insurance plan known as "Part A". 42 U.S.C. §§ 1395c-1395i-4. The Medicare Act also provides that people who are Medicare-eligible may voluntarily obtain supplementary insurance for other medical care, including certain physician services, hospital outpatient services, and other health services generally not covered under Part A. 42 U.S.C. §§ 1395j-1395w-4(j). This coverage is known as "Part B" and is the part of the Medicare statute involved in this appeal. To obtain this coverage, a Medicare-eligible person must pay insurance premiums. Once Part B coverage is obtained, the federal government pays 80% of the "reasonable costs" of outpatient hospital services and 80% of "reasonable charges" for physician services rendered to the insured. Reasonable costs and charges are established pursuant to the Medicare Act and regulations. Medicare patients themselves are responsible for paying the remaining "coinsurance" amount (20% of the reasonable costs of hospital services and 20% of the reasonable charges for physician services) and the annual deductible

The Medicaid Act, a statute separate from the Medicare Act, provides for a joint federal and state funded system which subsidizes medical care for the needy, regardless of age. If a state decides to participate in Medicaid, it proposes a plan which must be approved by the Secretary as conforming with federal requirements. 42 U.S.C. §§ 1396a(a), 1396a(b). The plan must include, among

other things, a schedule of payment rates which the state designates for the various kinds of medical care that a Medicaid patient might seek. Id. If the Secretary approves a state's plan, then the Federal government will assist the state in its reimbursement program with federal Medicaid funds. Those doctors and hospitals who are willing to treat Medicaid patients must agree to accept the designated Medicaid rate and not ask the patient to pay any money beyond that amount. 42 U.S.C. §§ 1320a-7b(d), formerly 42 U.S.C. § 1396h(d), and 42 C.F.R. § 447.15 (1989). New York State is a participant in the Medicaid program.

Returning to Medicare, the authors of the statute recognized in addressing the needs of Medicare patients that the poor Medicare-eligible (those who are eligible for Medicaid as well) generally would not be able to afford to enroll in the optional Part B Medicare coverage described above, because they would not be able to pay the insurance premiums, the 20% coinsurance and the annual deductible. The Act therefore provides, in 42 U.S.C. § 1395v, as elaborated by 42 C.F.R. § 407.40-407.50 (1990), that a state may agree to pay Part B Medicare insurance premiums on behalf of such poor elderly and disabled—whom we shall call "dual eligibles" or "crossovers"—and thereby acquire Part B Medicare coverage for them. By so doing, a state enrolls these crossovers in the Medicare Part B program just as less needy individuals enroll themselves when they individually choose to obtain Part B Medicare coverage and pay the insurance premiums. The federal government contributes funds to subsidize these state "buy-in" arrangements. New York has such a buy-in agreement with the Secretary.

Until 1987, New York paid not only the premiums but also the full cost-sharing amounts—the annual deductible and the 20% of reasonable costs or charges beyond what Medicare covers—for buy-in crossovers. Effective January 1, 1987, however, New York changed its practice by enacting the Regulation at issue in this case. The Regulation provided that in the case of crossovers covered by Part B through a buy-in agreement, New York will not pay any cost-sharing amounts except under one set of circumstances: When the 80% of reasonable costs or charges that Medicare reimburses amounts to less than the *Medicaid* rate, New York will pay the difference (Medicaid rate minus 80% reasonable costs or charges). A letter sent by New York State to health care providers illustrates the way that the Regulation operates:

> *Example*: Medicaid Fee or Rate = $45.00
>
> | *Medicare Approved* | *[80%] Medicare Paid* | *Balance Due* |
> |---|---|---|
> | $80.00 | $63.00 | $0.00 |
>
> A claim *should not* be submitted to Medicaid in this example.
>
> * * *
>
> *Example*: Medicaid Fee or Rate = $50.00
>
> | *Medicare Approved* | *[80%] Medicare Paid* | *Balance Due* |
> |---|---|---|
> | $60.00 | $48.00 | $2.00 |
>
> A claim *should* be submitted to Medicaid for the amount of $2.00.

The Regulation also prohibits Medicare providers from collecting any money from buy-in dual eligibles themselves.

One effect of the Regulation is that in New York State a dual eligible's providers may almost never collect more than 80% of their reasonable costs or charges, because the scheduled Medicaid payments are almost invariably less than 80% of the corresponding reasonable costs or charges of a given type of care under Medicare.[2] The Regulation has been modified to extend to a group of Medicare-eligible patients who are not poor enough to qualify for Medicaid but have incomes at or below the poverty line. This group is referred to as "qualified Medicare beneficiaries" (QMBs). 42 U.S.C. §§ 1396d(p)(1), 1396d(p)(2)(A). The QMBs may, like dual eligibles, be provided with Part B coverage through a buy-in agreement. 42 U.S.C. § 1396d(p)(3). The modified New York regulation limits New York's contribution to QMBs' cost-sharing coverage in the same way it does that of dual eligibles, on the basis of Medicaid rates.

II. Procedural History

This appeal arises out of a challenge to the Regulation as violative of the Medicare and Medicaid Acts. The Regulation has been approved by the Secretary. The approval was apparently not accompanied by an opinion or statement of reasons, and, we are told, was issued after commencement of this litigation. As indicated above, the Regulation became effective January 1, 1987. In the district court, plaintiffs and defendants both moved for sum-

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2 Because the record reflects that this conclusion is true and appellees do not dispute it, we shall assume that it is true and that New York in most cases now pays no part of Part B cost-sharing amounts.

mary judgment and defendants also moved to dismiss. While these motions were pending, Congress amended portions of the Social Security Act relevant to the action, and the parties addressed the effect of the amendments in letters to the district court. In an opinion and order dated March 18, 1991, the district court denied plaintiffs' motion and granted defendants' motions for dismissal of the complaint. The court reasoned that the Secretary's approval of the Regulation was based upon a permissible construction of the statute and that his interpretation was therefore entitled to deference. Thereafter, judgment was entered but subsequently vacated to permit plaintiffs to file an amended complaint, which included a new count based on amendments to the Medicaid Act that took effect in 1989. In April 1991, the district court entered a final judgment dismissing the amended complaint. This appeal followed.

III. Discussion

In this action, we must determine what New York State's responsibility is under the Medicare and Medicaid Acts for the annual deductible and 20% of reasonable costs or charges for patients who are dual eligibles or QMBs.

Appellants claim that the Regulation violates the Medicare and Medicaid Acts and that the Secretary's approval of the Regulation is unjustified. Appellees submit that under Chevron U.S.A., Inc. v. Natural Resources Defense Council, Inc., 467 U.S. 837, 844 (1984), we are required to defer to the Secretary's interpretation of the statute at issue unless the interpretation is "manifestly contrary" to the statute. Although we recognize, as did the district court, that the Medicare and Medicaid Acts are very com-

plicated, this is one of those comparatively rare instances when we should not defer to an administrator's interpretation of a statute. First, as we explain below, the Regulation is at odds with the clear intent of the statutes, both facially and as elaborated by legislative history. See Chevron, 467 U.S. at 842-43. Second, the Secretary's policy has been inconsistent with respect to the particular question at issue, and his current position is therefore entitled to less deference.

Medicare Act

Under the Medicare Act, a provider of services to a Medicare-eligible individual pursuant to the Medicare Act receives from the federal government, after deduction of the annual deductible, 80% of the reasonable costs or charges for such services. To collect the remaining portion of the provider's compensation, the provider "may charge such [Medicare-eligible] individual or other person (i) the amount of any deduction . . . and (ii) an amount equal to 20 per centum of the reasonable charges for such items and services . . . for which payment is made under part B . . . ." 42 § 1395cc(a)(2)(A). In other words, providers who furnish medical care to Medicare-eligible patients have the right to collect 100% of their reasonable costs or charges. Mercy Community Hosp. v. Heckler, 781 F.2d 1552, 1556-57 (11th Cir. 1986); St. James Hosp. v. Heckler, 760 F.2d 1460, 1472 (7th Cir. 1985), cert. denied, 474 U.S. 902 (1985); Menorah Medical Center v. Heckler, 768 F.2d 292, 296 (8th Cir. 1985); Regents of Univ. of Cal. v. Heckler, 771 F.2d 1182, 1188-89 (9th Cir. 1985). As appellants note, there is nowhere articulated in the Medicare Act or regulations an exception for dual eligibles or QMBs or any limitation on providers' express statutory right to recover their full reasonable costs or charges.

Despite this right, the Regulation at issue limits New York State's cost-sharing contribution to the Medicaid rate, an amount that is less than a provider's reasonable costs or charges, and prohibits providers from collecting anything from the patients themselves. In other words, the Regulation precludes providers who serve dual eligibles and QMBs pursuant to a buy-in arrangement from collecting more than 80% of their reasonable costs or charges in the overwhelming majority of cases.

The Regulation therefore appears, on its face, to violate the Medicare Act. The Secretary has nevertheless approved it, on the ground, accepted by the district court, that dual eligibles and QMBs are "primarily Medicaid patients" since they receive Part B Medicare coverage only because the State has enrolled them due to their status as Medicaid patients or poor individuals. In the Secretary's understanding, then, providers supplying care to such individuals are therefore not entitled to receive their reasonable costs or charges. We do not accept this reasoning. The Medicare Act on its face entitles providers to collect their reasonable costs or charges, an entitlement which is frustrated by the Regulation.

The Secretary's interpretation of dual eligibles as primarily Medicaid patients leads to some oddities. If Medicaid alone controlled with respect to dual eligibles, then it would make little sense for Medicare Part B to pay 80% of the Medicare rate for crossover care. If Medicaid were in fact the controlling program, then one would expect providers to be compensated at the Medicaid rate, instead of at 80% of the Medicare rate. Moreover, if crossovers were "primarily Medicaid patients," there would be no basis for Medicare to allow (as it does), as a hospital's bad debt expense, the uncollected Medicare cost-sharing amounts.

Beyond the face of the statute, the Senate Report accompanying the initial Medicare Act reveals that Congress sought to avoid a wealth-based, two-tiered system of health care for the elderly and certain disabled and indeed wanted to integrate *all* of those who were Medicare-eligible into the existing health care system. "Since the reasonable cost of the services would be covered, hospitals would not be deterred, because of nonpaying or underpaying patients in this aged group, from trying to provide the best of modern care." S. Rep. No. 404, 89th Cong., 1st Sess. 27 (1965), reprinted in 1965 U.S.C.C.A.N. 1943, 1967-68. "The provision of insurance against the covered costs would encourage participating institutions, agencies, and individuals to make the best of modern medicine more readily available to the aged." S. Rep. No. 404, 89th Cong., 1st Sess. at 24, 1965 U.S.C.C.A.N. at 1965.

Deeming dual eligibles and QMBs to be primarily Medicaid rather than Medicare patients prevents health care providers from collecting their reasonable costs or charges. Providers will consequently refrain from treating the most vulnerable of the elderly and disabled, those who are also poor. These groups are the true subjects of this appeal, and such a result is fundamentally at odds with Congress' vision in enacting the Medicare Act.

The buy-in provisions of Medicaid

The statutory section that specifies cost-sharing obligations for buy-ins is 42 U.S.C. § 1396a(a). It mandates that "[a] State plan for medical assistance [Medicaid] must . . . . provide," id. at § 1396a(a)(10), "for making medical assistance [Medicaid] available for medicare cost-sharing (as defined in section 1396d(p)(3) of this title) for qualified medicare beneficiaries described in

section 1396d(p)(1) . . . ." Id. at § 1396a(a)(10)(E). Cost-sharing is defined as Part B premiums, deductibles and the difference between the amount paid by Medicare (80%) and "the amount that would be paid under such section if any reference to '80 percent' therein were deemed a reference to '100 percent' [i.e., 20%]." 42 U.S.C. § 1396d(p)(3). The apparent meaning of this section is that the states that participate in Medicaid must allocate Medicaid funds to the enrollment of all dual eligibles and QMBs in Part B of Medicare and to the payment of 20% of reasonable costs or charges along with the annual deductibles incurred in this program.

Appellees claim that 42 U.S.C. § 1396a(a)(10)(E), quoted above, requires only that a state make Medicaid funds available (to pay cost-sharing amounts for buy-ins) up to the Medicaid rates. Appellees base this claim in part on Congress' simultaneous enactment in 1986 of § 1396a(a)(10)(E) and 42 U.S.C. § 1396a(n). The latter provision *permits* state reimbursement of cost-sharing amounts to QMBs to exceed the Medicaid rates. According to appellees, Congress would not simultaneously require (under (a)(10)(e)) and permit (under a(n)) the same result.

Although the argument has a surface appeal, upon analysis it is not persuasive. A statute requiring Medicaid funds to be made available for Medicare cost-sharing can only sensibly be read as requiring the funds to be made available to cover *all* Medicare cost-sharing. It is counter-intuitive that a statute requiring Medicaid funds to be made available for cost-sharing only to the extent of the Medicaid scheduled rates would not specify that qualification expressly. Furthermore, it appears that the reason that section a(n) authorizes payment beyond the Medicaid amount, when it is required by another section, is to clar-

ify that the Medicaid Act[3] does not prohibit a provider from accepting more than the Medicaid rate. To ensure that it be understood that providers of care to dual eligibles and QMBs are allowed and entitled to accept the state's full cost-sharing reimbursement, which (a)(10)(E) now mandates, a(n) gives providers this explicit authorization. As we hold today, a Medicare provider need not be satisfied with inadequate payment, i.e., less than reasonable costs or charges, even when that provider is treating a Medicare patient who happens also to be poor.

Predecessor to § 1396a(a)(10)(E)

To support their position that the Regulation is not contrary to the Medicare and Medicaid Acts, appellees rely on, among other things: a predecessor section to (a)(10)(E); a district court decision construing that earlier section; and legislative history. Before 42 U.S.C. § 1396a(a)(10)(E) was enacted, 42 U.S.C. § 1396a(a)(15) of the Medicaid Act governed a state's obligations to pay cost-sharing amounts for patients enrolled in Part B of Medicare under a buy-in arrangement. Although (a)(15) has been repealed, effective July 1, 1989, both parties in this case discuss it extensively. The district court's original judgment was addressed to the Secretary's interpretation of (a)(15) but this earlier judgment was vacated and the court later took into account the new (a)(10)(E) in rendering its final judgment. We shall analyze section (a)(15) for the guidance it provides in understanding the section that replaced it.

Prior to its repeal, (a)(15) required that a state Medicaid plan "provide where, under the plan, all of any deductible, cost sharing, or similar charge imposed with respect to

3 Specifically, 42 U.S.C. §§ 1320a-7b(d), formerly § 1396h(d), as elaborated by 42 C.F.R. § 447.15 (1989).

such individual [covered by Part B under a buy-in arrangement] . . . is not met, the portion thereof which is met shall be determined on a basis reasonably related . . . to such individual's income or his income and resources[.]" We understand this section to mean that if the state chooses not to pay the entire cost-sharing amount, the state must pay what remains after patients are allocated that portion of the liability commensurate with their ability to pay. Appellees claim that this section is only a limitation on how much a patient may be charged but not an indication of the minimum required of a state. We disagree. If the only purpose of the section were to put a ceiling on what a buy-in patient could be charged, the section could have stated as much. The significance of the statute as written is to provide two alternatives: either a state pays all cost-sharing amounts, or the state pays all except that portion allocated to the patient based on the patient's income and resources.

This understanding is also consistent with the providers' entitlement under Medicare to receive 100% of their reasonable costs or charges. Whether the state pays these costs or charges in full or whether part is allocated to the patient based on ability to pay, the provider is compensated and is therefore encouraged to continue to treat the poor elderly and disabled. This encouragement serves the goals of the Medicare Act. To the extent that (a)(15) guides our reading of successor section (a)(10)(E), the meaning of (a)(15) is consistent with a requirement for payment of all cost-sharing amounts by the state under (a)(10)(E). At most, (a)(15) might support an argument that (a)(10)(E) incorporated the alternative of allocating a portion of liability to patients based on their ability to pay.

Appellees also rely on Samuel v. California Dep't of Health Services, 570 F. Supp. 566 (N.D. Cal. 1983), to support the validity of the Regulation, at least under the former section (a)(15). In *Samuel*, a California district court upheld a state regulation which, like the Regulation here, limited the state's obligation to pay cost-sharing reimbursement for buy-in dual eligibles on the basis of the state's Medicaid rates. Id. at 574. The court also held that providers may not collect these amounts directly from dual eligibles, under what was formerly Medicaid, 42 U.S.C. § 1396h(d)(1) but has now been recodified as 42 U.S.C. §§ 1320a-7b(d). Id. Appellees assert that, as the court noted in *Samuel*, there was no clear intent in the legislative history of (a)(15) to protect providers by guaranteeing them reimbursement. 570 F. Supp. at 570. We disagree. Moreover, we would include in any examination of legislative history an examination of the history of the Medicare Act, since those individuals covered by Part B under (a)(15) are Medicare patients. As we have already indicated, the Senate Report accompanying the Medicare Act evidenced an intent to provide quality medical care for the elderly by compensating providers reasonably for their care. A guarantee of reimbursement, by protecting providers, protects patients.

Finally, appellees suggest that the "subsequent legislative history" of (a)(15) reveals that (a)(15) permitted the limitation of a state's cost-sharing obligations for dual eligibles on the basis of Medicaid rates. Appellees cite, for example, the House Report on the Medicare Catastrophic Coverage Act of 1988, which noted that "with respect to dual Medicaid-Medicare eligibles, some states pay the coinsurance even if the amount that Medicare pays for the service is higher than the State Medicaid payment rate, while others do not. . . . [I]f a State chooses to

pay some or all of the coinsurance in this circumstance [where the Medicaid rate is lower than what Medicare covers], Federal matching funds would, as under current law, be available for this cost." H.R. Rep. No. 105(II), 100th Cong., 2d Sess. 61 (1988), reprinted in 1988 U.S.C.C.A.N. 857, 884. Appellees also cite the legislative history of the Omnibus Budget Reconciliation Act of 1989, in which Congress recognized that most states limit reimbursement for dual eligibles to the Medicaid rate. H.R. Rep. No. 247, 101st Cong., 1st Sess. 364 (1989), reprinted in 1989 U.S.C.C.A.N. 1906, 2089-90.

As appellants rightly contend, the Committee reports cited, written more than 20 years after enactment of the Medicare and Medicaid Acts, do not mention or purport to construe (a)(15). They merely refer to what the Committee understood to be the *practice* of some states concerning payment of cost-sharing amounts. Furthermore, even when a subsequent House Committee has actually commented upon an earlier statute, the interpretation carries little weight with the courts. See Oscar Mayer & Co. v. Evans, 441 U.S. 750, 758 (1979); Pierce v. Underwood, 487 U.S. 552, 566 (1988); United States v. Price, 361 U.S. 304, 313 (1960). We accordingly refuse to read the subsequent legislative history which appellant cites as evidence that the Regulation is valid, under either the former (a)(15) or the current (a)(10)(E).

Inconsistency of the Secretary's policy

As we stated above, where—as here—an issue is a question of law involving statutory construction and analysis of Congressional intent, and the meaning of the statute is clear, an agency interpretation is entitled to less deference. INS v. Cardoza-Fonseca, 480 U.S. 421, 446-48 (1987); Chevron, 467 U.S. at 843 n.9; International

Union, United Automobile, Aerospace and Agricultural Implement Workers of America v. Brock, 816 F.2d 761, 764 (D.C. Cir. 1987). But even where a statute is ambiguous or silent on a particular question—as we do not believe the Medicare and Medicaid statutes are with respect to the question before us—where the Secretary's policy is inconsistent with an earlier policy, that inconsistency is a ground for rejecting a claim for deference. In *Cardoza-Fonseca*, for example, the Supreme Court stated that "[a]n agency interpretation of a relevant provision which conflicts with the agency's earlier interpretation is 'entitled to considerably less deference' than a consistently held agency view." 480 U.S. at 446 n.30 (citations omitted). In Samaritan Health Service v. Bowen, the Court of Appeals for the D.C. Circuit struck down as unreasonable the Secretary's interpretation of a provision of Medicare, an interpretation that had led to the denial of Medicare reimbursement claims. The court stated in its opinion that "[a]ny deference that an interpretive rule may claim depends on [among other things] . . . 'its consistency with earlier and later pronouncements . . .' ". 811 F.2d 1524, 1529 (D.C. Cir. 1987), citing Skidmore v. Swift & Co., 323 U.S. 134, 140 (1944). The expertise in statutory interpretation to which we normally defer becomes dubious when the expert cannot make up its own mind.

This case presents an example of such inconsistency. Although appellees assert that the Secretary's approval of the Regulation accords with his longstanding policy, this assertion is not entirely accurate. In a 1981 policy memorandum, the Secretary announced that with respect to dual eligibles who have buy-in Medicare coverage, "if the MediCal [Medicaid] agency has made no payment at all, the physician/supplier may collect coinsurance [i.e. 20%

of reasonable charges] and deductibles from the MediCal [Medicaid] eligible patient." Department of Health & Human Services Memorandum, September 29, 1981 (emphasis added). As we stated above, under the New York Regulation, the providers for most dual eligibles and QMBs who have buy-in Part B coverage will receive nothing from Medicaid because the 80% which Medicare pays will exceed the Medicaid rate. Therefore, the providers for these buy-in patients would have been authorized, under the Secretary's 1981 policy, to collect coinsurance from their patients directly. In *Samuel*, the California district court case we discussed above, the Secretary urged this position with the State of California:

> Suppose, however, the doctor chooses not to bill MediCal [Medicaid] but only Medicare. In that case the doctor, depending on his conscience, may take his 80% reimbursement from Medicare and bill the beneficiary the remaining 20%. Note that this is totally outside the State plan and beyond the reach of any proscriptions which might be imposed under the Medicaid Act; whether the doctor bills the patient in the Medicare-only situation is a matter between the doctor and his patient. The State cannot control physicians and cannot stop them from billing certain *charges permitted by the federal government.* (emphasis added)

Similarly, the Secretary there asserted:

> What the plaintiffs are really complaining about is the practice of some doctors in charging co-payments to their patients. *Congress has seen fit to allow the doctors discretion to impose such charges and if plaintiffs are unhappy about it their remedy is to seek corrective legislation.* (emphasis added)

Thus, in 1981 the Secretary presumed that providers have the right to receive 100% of their reasonable costs or charges for services to patients enrolled in Part B Medicare pursuant to a buy-in arrangement, a right that providers could assert even against indigent, Medicaid-eligible patients. The Secretary did not consider such patients to be "primarily Medicaid" in 1981. We reject the Secretary's reading of the statutes to suggest that these patients are "primarily Medicaid" in 1991.[4]

IV. Conclusion

When faced with a complicated statutory scheme, there is a strong temptation for judges to assume that the scheme has no fixed meaning or purpose and simply to defer to the interpretation given the statutory text by an administrative agency. In a society as complex as ours, many statutes are of necessity complicated. However, complexity is not the same as ambiguity. Congress passes legislation with specific purposes in mind. When the ordinary tools of statutory construction permit us to do so, we must attempt to discover those purposes from the text,

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4 It is true that in Chevron, the Federal Agency at issue—the E.P.A.—had adopted different policies with respect to the definition of "stationary source" under the Clean Air Act from one administration to the next. See Chevron, 467 U.S. at 863-64. However, these policies were both within the policy-making authority implicitly delegated by Congress to the agency in flexibly implementing its statute. In our case, by contrast, the position that Medicare providers are entitled to collect their fees from dual eligibles (the Secretary's position in 1981) is absolutely at odds with the position that the providers are bound to accept only the Medicaid scheduled amount for dual eligibles (the Secretary's position in 1991). Congress intended either that buy-in patients be responsible for cost-sharing or that they not be responsible for cost-sharing. The Secretary changed policies not because he found that one of two permissible policies was more desirable in implementing the unspoken intent of Congress. The Secretary changed because, as he submits in his brief, he now believes that the previous policy was in error.

structure and history of the acts in question. Sometimes we will find that Congress has not addressed the problem posed by a particular case. In such circumstances, we are required to defer to administrative expertise. But where we confront a statute that evinces a legislative purpose clearly at odds with the proffered administrative interpretation, we should not defer. Indeed, our constitutional duty to interpret the law requires us to effectuate the legislative intent notwithstanding the contrary administrative view.

We have considered all of appellees' arguments and, for the reasons set forth above, we reverse the judgment of the district court and remand with directions to grant summary judgment to appellants.

CARDAMONE, *Circuit Judge*, dissenting:

I respectfully dissent from my colleagues' conclusion that the views of the state and federal administrative officers, appellees here, are at odds with the thrust of the legislative purpose. In a climate of budgetary constraint, appellee Commissioner Perales of New York promulgated a regulation, which was approved by appellee Secretary Sullivan of the U.S. Department of Health and Human Services, that saves public money in the delivery of medical care. My colleagues find the regulation at issue contrary to both the Medicare and Medicaid Acts facially and when viewed in light of legislative history. They also believe the Secretary's policy in this area has been inconsistent and is therefore entitled to little or no deference. It is my belief that appellees each acted well within their

discretionary authority and consistent with legislative aims.

The thrust of appellants' argument is that New York's 18 NYCRR § 360.10 fails to satisfy the reimbursement requirements of the Medicare Act. The Secretary, on the other hand, has determined that crossovers and QMBs are "primarily Medicaid patients," and accordingly §360.10 need satisfy only the lesser reimbursement requirements of the Medicaid Act. The majority has adopted appellants' position as their premise, that is, crossovers and QMBs are for all purposes Medicare beneficiaries. It is conceded that were crossovers and QMBs to be classified for all purposes as *Medicare* beneficiaries, § 360.10 would violate the Medicare Act because it operates to preclude service providers treating such dual eligibles from collecting 100 percent of their reasonable costs or charges. But since whether dual eligibles should be classified for all purposes as Medicare beneficiaries is the precise question we have been called upon to decide, it is inappropriate to adopt appellants' view as a premise. Before analyzing the manner in which § 360.10 affects reimbursement of providers treating crossovers or QMBs, it must first be determined whether that effect should be analyzed under the Medicare Act or the Medicaid Act.

A. *Deference to Administrative Agency Generally*

It has long been recognized that it is inappropriate for courts to resolve competing legislative policy objectives and that latitude must therefore be accorded an agency's determination of how best to exercise the authority delegated to it. *See, e.g., Chevron USA Inc. v. Natural Resources Defense Council, Inc.*, 467 U.S. 837, 843 (1984) (quoting *Morton v. Ruiz*, 415 U.S. 199, 231

(1974)); *United States v. Shimer*, 367 U.S. 374, 383 (1961). In the instant case the majority's statement that "there is nowhere articulated in the Medicare Act or regulations an exception for dual eligibles or QMBs or any limitation on providers' express statutory right to recover their full reasonable costs or charges" effectively places the burden on the Secretary to identify an express delegation of authority. This view ignores the well-settled standard for determining when authority has been delegated to an agency. The test is not whether the Medicare Act explicitly allows crossovers and QMBs to be classified for purposes of *Part B* service provider reimbursement as primarily Medicaid recipients. Rather, the appropriate inquiry is whether there is anything in the statutes or the legislative history clearly evincing a contrary congressional purpose. *See United States v. Fulton*, 475 U.S. 657, 666 (1986) (reasonable agency interpretation of statute to be upheld absent "definitive contrary legislative command"); *Chevron*, 467 U.S. at 843 (court may not impose its own construction of statute in place of agency's if "*Congress has not directly addressed the precise question at issue*") (emphasis added); *accord Weeks v. Quinlan*, 838 F.2d 41, 44 (2d Cir. 1988).

My colleagues' approach on this point overlooks the fact that a delegation of agency authority may be implicit rather than explicit. *Chevron*, 467 U.S. at 844. Consequently, "if the statute is *silent or ambiguous with respect to the specific issue*," deference is warranted. *Id.* at 843 (emphasis added); *see also Fulton*, 475 U.S. at 666-67 (statute addressing "rate[s]" did not specifically address interim rates, thus deference to agency warranted). Nothing in the language of these Acts itself fairly supports an inference that Congress *specifically* intended crossover and QMB *Part B* service providers to be reimbursed at the

Medicare reasonable cost/charge level. In fact, the majority's efforts to construe ambiguous and conflicting provisions of the Medicare and Medicaid Acts as precluding limiting crossover and QMB Part B service provider reimbursement to Medicaid levels demonstrate this. The majority's interpretation of these Acts simply does not lay out a "clear" *plan of Congress* contrary to the Secretary's construction of the same statutes.

B. *Legislative History*

Appellants rely on legislative history that they contend demonstrates Congress' purpose to classify similarly all Medicare beneficiaries. Citing legislative history, the majority suggests that Congress wanted to avoid a "wealth-based, two-tiered system of health care" for those eligible for Medicare. The cited legislative history addresses only Medicare *Part A*. The relevant portion of the Senate report is as follows:

A. HEALTH CARE

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> The first of the two insurance programs [*i.e.*, Medicare Part A] consists of protection against the costs of hospital and related care . . . .
>
> ***
>
> The second of the two insurance programs [*i.e.*, Medicare Part B] is a *voluntary supplementary medical insurance plan* that would cover a substantial part of the cost of physicians' services and a number of other health items and services not covered under the hospital insurance program . . . . The combined coverage of the two insurance plans would result in

protection for the elderly of a quality that only a few older people can now afford. Most elderly people can be expected to have the protection of both of these insurance programs.

The provision of insurance [*i.e.*, Part A and Part B] against the covered costs would encourage participating institutions, agencies, and individuals to make the best of modern medicine more readily available to the aged.

***

1. BASIC PLAN—HOSPITAL INSURANCE

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(b) Benefits

***

(1) Inpatient hospital benefits

***

Covered Services.—The reasonable cost of service ordinarily provided to inpatients by hospitals . . . would be paid for . . . . Since the reasonable cost of the services would be covered, hospitals would not be deterred, because of nonpaying or underpaying patients in this aged group, from trying to provide the best of modern care . . .

***

Payments would not be made under the hospital insurance plan for the services of physicians . . .

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2. VOLUNTARY SUPPLEMENTARY PLAN

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(b) Benefits under the voluntary supplementary plan

The voluntary supplementary plan would provide protection that *builds upon the protection provided by the hospital insurance plan.* It would cover physicians' services, additional home health visits, and a variety of other health services, not covered under the hospital insurance plan. The beneficiary would pay the first $50 of expenses he incurs each year for services of the type covered under the plan. Above this deductible amount, the plan would pay 80 percent of the reasonable costs in the case of services provided by an institution or home health agency and 80 percent of reasonable charges for other covered services, with normally 20 percent being paid by the beneficiary.

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(c) Method of payment under the voluntary supplementary plan

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. . . In general, under the supplementary plan a provider of services . . . could charge a beneficiary the $50 deductible and 20 percent of the reasonable charges (in excess of the $50 deductible) for the covered services.

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5. ACTUARIAL COST ESTIMATES FOR THE VOLUNTARY SUPPLEMENTARY MEDICAL INSURANCE SYSTEM

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(b) Financing policy

(1) Self-supporting nature of system

The committee has recommended the establishment of a supplementary medical insurance program that can be voluntarily elected, on an individual basis, by virtually all persons aged 65 and over . . . *This program is intended to be completely self-supporting from the contributions of covered individuals and from the equal-matching contributions from the general fund of the Treasury* . . . .

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S. Rep. No. 404, 89th Cong., 1st Sess., *reprinted in* 1965 U.S. Code & Cong. Admin. News 1943, 1964-2011 (emphasis added).

Reading this Senate Report it is difficult to accept the majority's implicit assertion that the legislative history "clearly" shows Congress aimed for crossover and QMB *Part B* service providers to be reimbursed by the state at the Medicare reasonable cost/charge level. Quite the contrary, to the extent that Congress desired to ensure reasonable cost/charge reimbursement in order to encourage "the best of modern care," such concern seems to have been directed to the Part A program. This is understandable. As the legislative history indicates, Congress distinguished between the services covered under Part A and Part B, probably based on the varying "medical necessity" of the services covered. *Compare id.* at 1966-69, *with id.* at 1982-83; *see also id.* at 2019-20; *cf. Schweiker v. Hogan*, 457 U.S. 569, 590 (1982) (public assistance programs often cannot provide everyone with meaningful benefits in equal measure). From this distinction it follows that the legislature's desire to ensure reasonable cost/charge reimbursement in order to encourage the best of medical care as to Part A services does not control in

the context of the "less medically necessary" services covered in Part B. Moreover, the legislative history demonstrates that in discussing the Part B program Congress envisioned coinsurance, deductible and premium payments would be made by the beneficiary. In light of the fact that crossovers and QMBs cannot pay such charges, it is disingenuous to suggest that in discussing full reasonable cost/charge reimbursement for Part B service providers Congress had within its contemplation crossovers and QMBs. *See Chevron*, 467 U.S. at 862.

The dichotomy between the Part A and Part B programs with respect to dual eligibles is also logical in light of the programs' differing qualification requirements. A Medicare beneficiary—either pure or dual eligible—is automatically entitled to Part A services. Consequently, classifying dual eligibles differently than pure Medicare beneficiaries with respect to Part A services would be arbitrary, insofar as their status as dual eligibles is irrelevant with respect to their entitlement to such services. But neither pure nor dual eligible Medicare beneficiaries are automatically entitled to Part B services. A pure Medicare beneficiary is entitled to Part B services because he or she pays the enrollment premiums; a dual eligible is entitled to such services because—by virtue of his or her status as a Medicaid recipient—the state pays the enrollment premiums. Thus, there is a difference between pure and dual eligible Medicare beneficiaries in respect to Part B services. *See Schweiker*, 457 U.S. at 588 (inconsistent to require comparable treatment among two groups participating in a program when one group may be excluded entirely from participation).

The majority's concern that crossovers and QMBs not be deprived of important medical care is misplaced. First,

it does not follow that because crossover and QMB Part B service providers are reimbursed at the Medicaid rather than the Medicare rate there will be inadequate financial incentive to provide such care. Although admittedly with less incentive fewer providers will offer such care, that is not the crucial question. What is critical is whether reimbursement at the Medicaid level is so low that an "insufficient" number of providers will have a financial incentive to provide services. *See* 42 C.F.R. § 447.204. Nothing in the record supports such a dire conclusion. *See Samuel v. Cal. Dep't of Health Servs.*, 570 F. Supp. 566, 573-74 (N.D. Cal. 1983); *see also Mass. Medical Soc'y v. Dukakis*, 815 F.2d 790, 794-95 (1st Cir.), *cert. denied*, 484 U.S. 896 (1987) (upholding state statute forbidding doctors to bill Medicare patients for fees beyond those reimbursed by Medicare against challenge based on theory that doctors might find Medicare "reasonable" charge unreasonably low, thereby refusing to treat Medicare patients). Moreover, the disincentive theory seems intuitively untenable since, were it true, no doctors or hospitals would ever treat Medicaid patients.

Second, as a result of the majority's holding, it appears if it cannot afford to provide reimbursement up to the Medicare level, New York now has the following three options: (1) permit service providers to bill crossovers and QMBs directly for the coinsurance and deductible amounts—as with pure Medicare beneficiaries. But because, unlike pure Medicare beneficiaries, crossovers and QMBs are by definition unable to pay even the Part B enrollment premiums on their own, this option will not "help" these beneficiaries; (2) discontinue its payment of Part B enrollment premiums for crossovers and QMBs. This option also will not help to ensure that these individuals receive the "best of medical care;" or (3) simply

terminate enrollment in the Part B program for dual eligibles and provide the same services for them directly under the umbrella of the Medicaid program. *See Samuel*, 570 F. Supp. at 573. In that case those providing the services would be reimbursed only at the Medicaid rate and the recipients would receive precisely the same care as presently. Thus, it appears that in focusing on the fact that the services at issue are nominally part of the Medicare program--rather than recognizing that the beneficiaries actually receive these services through the Medicaid program—the majority has elevated judicial form over the substance of what the State of New York is doing and continues to have the option to do.

Further, in relying on the legislative history, my colleagues fail to cite provisions of the 1965 Senate Report that support the proposition that Congress did not aim to *require* crossover and QMB Part B service providers be reimbursed by the state at the Medicare rate. In discussing the Medicaid Act, the report states:

> No deduction, cost sharing or similar charge may be imposed with respect to inpatient hospital services furnished under the plan. This provision is related to another provision in the bill which *requires States to pay* reasonable costs *for inpatient hospital services* provided under the plan. Taken together, these provisions give assurance that the hospital bill incurred by a needy individual [*i.e.*, Medicaid recipient] *shall be paid in full* under the provisions of the State plan . . . and that the States may not expect to require the individual to use his income or resources . . . toward that bill . . . .
>
> For any other items of medical assistance furnished under the plan, a charge of any kind *may* be imposed

only if the State so chooses, and the charge must be reasonably related to the recipient's income or his income and resources. The same limitations apply in the case of any enrollment fee, premium, or similar charge imposed with respect to inpatient hospital services . . . .

The hospital insurance benefit program included under other provisions of the bill [*i.e.*, Medicare Part A] provides for a deductible which *must be paid* in connection with the individual's claim for hospitalization benefits. The committee is concerned that *hospitalization be readily available* to needy persons and that the necessity of their paying deductibles or cost sharing shall not be a hardship on them or a *factor which may prevent their receiving the hospitalization they need. For this reason*, the committee's bill provides that *the State make provisions*, for individuals 65 years or older who are included in the [Medicaid] plan [*i.e.*, crossovers], of the cost of any deductible or cost sharing imposed with respect to individuals under the program established by the hospital insurance [*i.e.*, Part A] provisions of the bill.

A State medical assistance plan may provide for the payment in full of any deductibles or cost sharing under the insurance program established by Part B of title XVIII. In the event, however, the State plan provides for the individual to assume a portion of such costs, such portion shall be determined on a basis reasonably related to the individual's income, or income and resources . . .

S. Rep. No. 404, 89th Cong., 1st Sess., *reprinted in* 1965 U.S. Code & Cong. Admin. News 1943, 2019-20 (emphasis added).

Consequently, while the legislative history cited by the majority may suggest that Congress did not distinguish between pure and dual eligible Medicare beneficiaries in order to assure equal care, when read in its entirety this same history equally demonstrates Congress' purpose was limited at most to Part A services. In fact, while explicitly commanding states to pay dual eligibles' Part A cost sharing and deductible amounts (and providing its reasons for this direction), the Senate Report contains no comparable direction with respect to Part B charges, though states were free not to impose such charges on the recipient. Therefore, it seems incorrect to state that the statutes or their legislative history "clearly" or "demonstrably" indicate a specific congressional aim contrary to the Secretary's interpretation on the issue presented—whether crossover and QMB *Part B* service providers must be reimbursed by the state at the Medicare reasonable cost/charge level.

C. *Secretary's View*

The majority further states that "where the Secretary's policy is inconsistent with an earlier policy, that inconsistency is a ground for rejecting a claim for deference." Again, this formulation of the relevant inquiry seems to me to miss the point. That an agency has changed its interpretation of the statute it is charged with administering is itself not dispositive on the question of whether deference should be accorded the new interpretation. *See, e.g., Chevron*, 467 U.S. at 863-64. What is more important is whether the agency's change in position rests on a "well-considered basis." *See Robertson v. Methow Valley Citizens Council*, 490 U.S. 332, 355-56 (1989). In the instant case, the Secretary having been advised by the

District Court for the Northern District of California in *Samuel* that he erroneously discerned Congress' purpose provides powerful support for concluding that the Secretary's changed interpretation is well-considered. It is ironic that today's holding tells the Secretary he must forbid in New York what he has previously been ordered to permit in California.

D. *Reasonableness*

Once it is determined that the Secretary's interpretation of the statute he is charged with administering is entitled to deference because of an implicit delegation of authority, judicial review is limited to asking whether that interpretation is "reasonable" or "permissible." *See, e.g., Clarke v. Securities Indus. Ass'n*, 479 U.S., 388, 403-04 (1987); *Weeks*, 838 F.2d at 44. Because we need only ask whether the Secretary's interpretation is a reasonable or permissible construction of the statute, the fact that the Secretary's interpretation leads to "some oddities" or is in some respects "counter-intuitive" is not grounds for failing to accord it deference. *See, e.g., Chevron*, 467 U.S. at 843 n.11. Moreover, the reasonableness of the Secretary's interpretation should be analyzed in light not only of the purposes underlying the Medicare Act, but also with regard to the purposes underlying the Medicaid Act. *See N.Y. State Dep't of Social Servs. v. Bowen*, 846 F.2d 129, 133 (2d Cir. 1988).

Medicaid is a joint state-federal program under which states choosing to participate receive federal funding to help subsidize the states' costs in providing Medicaid services. *Harris v. McRae*, 448 U.S. 297, 301 (1980). Reimbursement under Medicaid need not amount to the providers' Medicare-level reasonable cost/charge. *See*,

e.g., 42 U.S.C. § 1320a-7b(d); 42 C.F.R. § 447.15. Rather, in part due to both the states' and the federal government's interest in containing Medicaid costs, *see*, *Schweiker*, 457 U.S. at 590; *State of N.Y. by Perales v. Bowen*, 811 F.2d 776, 779 (2d Cir. 1987), state funding determinations need only accord with "reasonable standards . . . for determining . . . the extent of medical assistance under [its] plan which . . . are consistent with the objectives" of Medicaid. *Harris*, 448 U.S. at 302 (quoting 42 U.S.C. § 1396a(a)(17)); *see also State of N.Y. by Perales v. Sullivan*, 894 F.2d 20, 22 (2d Cir. 1990); 42 U.S.C. §§ 1396a(a)(13)(A), 1396a(a)(30). That general objective is "*as far as practicable*, to furnish medical assistance to individuals whose income and resources are insufficient to meet the costs of necessary medical services." *Beal v. Doe*, 432 U.S. 438, 444 (1977) (emphasis added); *see also Alexander v. Choate*, 469 U.S. 287, 303 (1985) (Medicaid provides a particular package of health services; package has general aim of assuring individuals receive necessary medical care, but the benefit provided remains individual services offered—not "adequate health care").

Thus, because of the purpose of Medicaid and its structure as a cooperative federal and state endeavor, *Harris*, 448 U.S. at 308, it has long been accepted that states have substantial discretion in determining the amount and scope of services to provide. *E.g.*, *Schweiker*, 457 U.S. at 589-91; *Alexander*, 469 U.S. at 303. Necessarily, this discretion allows the states latitude to balance medical and economic concerns in light of that state's particular circumstances in establishing Medicaid rates. *See State of Wis. Dep't of Health v. Bowen*, 797 F.2d 391, 397 (7th Cir. 1986), *cert. dismissed*, 485 U.S. 1017 (1988); *State of N.Y. by Perales*, 894 F.2d at 24; *Miss. Hosp. Ass'n, Inc. v.*

Heckler, 701 F.2d 511, 515 (5th Cir. 1983); *see also Mass. Medical Soc'y*, 815 F.2d at 795.

In this case, the Secretary was called upon to resolve the competing policy concerns expressed in the Medicare and Medicaid Acts and determine the extent to which allowing the state to limit crossover and QMB Part B service providers to Medicaid-level reimbursement impacts upon the availability of such services for those individuals in that state in light of that state's fiscal condition. It is not up to the majority to substitute its view for the Secretary's as to how best to accommodate these concerns. *E.g.*, *Shimer*, 367 U.S. at 383, 385; *Chevron*, 467 U.S. at 864-66.

In my view there simply are no compelling indications that appellees' view is wrong. Hence, I vote to affirm the district court's grant of summary judgment in their favor.

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

FILED MARCH 13, 1991

87 CIV. 4896 (MJL)

NEW YORK CITY HEALTH AND HOSPITALS CORPORATION, MEDICAL SOCIETY OF THE STATE OF NEW YORK, SIDNEY FINKEL, and JOHN A. BLESKI,

Plaintiffs,

—against—

CESAR A. PERALES, as Commissioner of Social Services of the State of New York and OTIS R. BOWEN, as Secretary of the United States Department of Health and Human Services,

Defendants.

OPINION AND ORDER

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MARY JOHNSON LOWE, *D.J.*

Before this Court is plaintiffs' motion pursuant to Fed.R.Civ.P. 56 for summary judgment on Counts I through III of their Complaint. Defendant Otis R. Bown ("Bowen" or the "Secretary"), Secretary of the United States Department of

Health and Human Services, cross-moves for summary judgment on these counts. Defendant Cesar A. Perales ("Perales"), Commissioner of Social Services of the State of New York, also cross-moves under Fed.R.Civ.P. 12(b)(6). For the reasons stated below, defendants' motions are granted and plaintiffs' motion is denied.

BACKGROUND

This action challenges an amendment to a New York State Regulation which, according to plaintiffs, would either reduce or eliminate entirely their federal statutory right to receive certain payments for health care services rendered by them to persons who are eligible for benefits under both the Medicare and Medicaid Programs. Because the issues raised here involve interpretation of a Congressional act whose construction has been characterized as "Byzantine,"[1] we take some pains to set out the relevant portions of the statutory scheme.

The Medicare Program

Congress established the Medicare Program in 1965 as Title XVIII of the Social Security Act, 42 U.S.C. §§ 1395-1395zz. The Medicare program is a purely federal one and provides reimbursement for medical care to the aged and to certain disabled persons under 65 years of age. Part B of the Medicare Program, with which this litigation is concerned, is a voluntary supplementary program for Medicare-eligibles who choose to enroll. It pays for certain physician services, hospital outpatient services, and other health services generally not covered under Part A of the program.

The Part B Medicare Program is financed both through premium payments made by the beneficiary and through contri-

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1 To quote in full:

> "The Social Security Act is among the most intricate ever drafted by Congress. Its Byzantine construction, as Judge Friendly has observed, makes the Act 'almost unintelligible to the initiated.' "

Schweiker v. Gray Panthers, 453 U.S. 34, 43 (1981) (quoting *Friedman v. Berger*, 547 F.2d 724, 727, n.7 (2d Cir. 1976), *cert. denied*, 430 U.S. 984 (1977)).

butions from the federal government. The beneficiary is also required to pay an annual deductible. Above that deductible amount, Medicare pays 80% of the "reasonable costs" of hospital services, and 80% of the "reasonable charges" of physicians' services.[2] The beneficiary remains responsible for the 20% coinsurance amount.

The Medicaid Program

In 1965, Congress also enacted the Medicaid Program as Title XIX of the Social Security Act, 42 U.S.C. §§ 1396 *et seq.* This program was designed to reimburse certain medical costs for needy persons. The Medicaid Program is a cooperative one, funded by both the federal and state governments. States choosing to participate in it, however, must have their medical assistance plan approved by the Secretary of the United States Department of Health and Human Services (the "Secretary").

Payments under the Medicaid Program are generally not based upon "reasonable costs" or "reasonable charges"; indeed, they are generally lower.[3] Moreover, federal regulations mandate that the state plan require the designated state agency[4] to limit participation in the Medicaid program to providers who accept, as payment in full, the amount paid for the medical services by the Medicaid program. 42 C.F.R. § 447.15.

The Buy-In Agreement and The Instant Controversy

Under the Medicare statute, 42 U.S.C. § 1395v, a state may enter into an agreement with the Secretary by which it enrolls Medicaid recipients who are also eligible for Medicare

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2 Those costs and charges are calculated pursuant to the Medicare Act and Regulations.

3 Plaintiffs argue that New York state has established Medicaid reimbursement rates that are in all cases lower than "reasonable cost" or "reasonable charges" established by Medicare Part B for the same services, and which, in almost all cases, are lower than 80% of such "reasonable costs" or "reasonable charges." *See Plaintiffs' Memorandum of Law in Support of Summary Judgment at 9.*

4 In the instant case, the designated state agency is the Department of Social Services of the State of New York (the "Department").

("crossovers" or "dual eligibles") in the voluntary Medicare Part B program. Under this agreement, the state, rather than the beneficiary, pays the Medicare premiums.

New York state has entered into such a buy-in agreement. In addition to paying the premiums under this arrangment, New York also paid, up until January 1, 1987, the full cost-sharing amounts on behalf of its crossover beneficiaries—*i.e.* the Medicare deductibles and the 20% coinsurance amounts.

On March 16, 1988, however, the Secretary approved a proposed amendment to the New York state plan governing payments under New York's buy-in agreement. That amendment, 18 New York Code of Rules and Regulations ("NYCRR") 360.10,[5] which became retroactively effective on January 1, 1987, provides that the State's Medicaid agency will pay Medicare co-insurance and deductible amounts for crossovers only up to the approved Medicaid rate. The amendment also prohibits providers agreeing to treat crossovers from seeking to recover, from the patients themselves, any of the Medicare coinsurance or deductible amounts.[6] In short, the amendment

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5 Since the commencement of this litigation, § 360.10 has been repealed and recodified as 18 N.Y.C.R.R. § 360-7.7, effective March 1, 1989. However, for the purpose of consistency with the papers submitted by the parties, the regulation is referred to in this Order by its original number, 360.10.

6 Section 360.10 reads in part:

. . . (b) Medical assistance (*i.e.*. Medicaid payments) shall include the amount of any deductible or coinsurance liabilities under Medicare Part B for all eligible applicants or recipients to the extent that:

(1) When the Medicare payment to a provider of a Part B benefit is less than the established medical assistance fee or rate for the benefit, the Department shall pay the provider an amount equal to the difference between the Medicare Part B payment and the lower of:

(i) the established medical assistance fee or rate; or
(ii) the Medicare approved amount.

(2) When the Medicare payment to a provider of a Part B benefit equals or exceeds the established medical assistance fee or rate for the benefit, the Department shall pay no Part B coinsurance or deductible amounts to the provider. . .

(d) Providers of care, services, supplies or equipment covered under Medicare Part B and the medical assistance program shall accept assignment of a person's right to receive Medicare Part B payments and shall not seek to recover Medicare Part B deductible or coinsurance amounts from such person if such person is also eligible for medical assistance.

requires the provider to essentially treat the crossover patient as a Medicaid recipient and to accept, as payment in full for his Medicare services, an amount no greater than the Medicaid-approved rate.[7]

On July 10, 1987, plaintiffs—all of whom are health care providers[8]—filed the instant action challenging § 360.10. Specifically, plaintiffs contend that § 360.10: 1) deprives providers, such as themselves, of their claimed statutory right to reimbursement of their reasonable costs or charges in violation of the *Medicare* Act (Count I); 2) violates the *Medicare*

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7 Operation of the challenged amendment is illustrated below:

1) If the Medicare payment exceeds the Medicaid rate or fee, Medicaid need not pay any additional amount:

Medicaid Fee or Rate = $45

Medicare Approved	*Medicare Paid*	*Balance Due*
$80	(80% of $80) or $64	$0

2) If the Medicare payment is less than the Medicaid rate or fee, Medicaid must pay the difference between the Medicare Paid amount and the lower of the Medicaid fee/ rate or the Medicare approved amount:

Medicaid Fee or Rate = $70

Medicare Approved	*Medicare Paid*	*Balance Due*
$60	(80% of $60) or $48	$12 ($60-$48)

Medicaid Fee or Rate = $50

Medicare Approved	*Medicare Paid*	*Balance Due*
$60	(80% of $60) or $48	$2 ($50-$48)

8 Plaintiff New York City Health and Hospitals Corporation ("HHC") is a New York public benefit corporation and is a principal provider of hospital services, including outpatient hospital services, to the low-income population of New York City who are intended beneficiaries of the Medicaid Act. Complaint at ¶ 6.

Plaintiff Medical Society of the State of New York ("MSSNY") is a domestic non-profit corporation and is the largest voluntary organization of physicians in New York. Many of its members treat crossovers. *Id.* at ¶ 7.

Plaintiff Sidney Finkel, M.D., is a medical doctor who practices in Westbury, Long Island. He is a participating physician in the Medicare program and a provider in the Medicaid program. *Id.* at ¶ 8.

Plaintiff John A. Bleski, M.D., is a medical doctor who practices in Kingston, New York. He is a participating physician in the Medicare program and treats a number of regular patients who are dually eligible under both the Medicare and Medicaid programs. *Id.* at ¶ 9.

Act's prohibition of cost-shifting (Count II); 3) violates specified portions of the *Medicaid* Act's crossover provisions (Count III); and 4) deprives plaintiffs of their property interests in violation of the Due Process Clause of the Fourteenth Amendment (Count IV).[9]

Since the parties first submitted their motions and cross-motions, Congress has twice amended the Medicaid Act in areas relevant to this litigation. Those amendments, and their effect on the instant controversy, are the subject of four letters to this Court and are also taken under consideration here. One such amendment has led plaintiffs to assert a fifth cause of action under the new § 1396(a)(10)(E). However, plaintiffs' Complaint has not been formally amended to state this additional cause of action.[10]

DISCUSSION

Standard of Review

When a court is presented with issues of statutory construction, it must address two essential questions:

> First, always, is the question whether Congress has directly spoken to the precise question at issue. If the intent of Congress is clear, that is the end of the matter; for the court, as well as the agency, must give effect to the unambiguously expressed intent of Congress. If, however, the court determines that Congress has not directly addressed the precise question at issue, the court does not simply impose its own construction on the statute, as would be necessary in the absence of an administrative interpretation. Rather, . . . the question for the court is

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9 Plaintiffs contend that "[i]n light of the clear statutory violations [enumerated in Counts I-III], it is not necessary to reach the constitutional claim and that [such claim is therefore] not presented on this motion." Plaintiffs' Memorandum of Law at 16-17.

10 Plaintiffs are hereby directed to formally amend their Complaint, if at all, within thirty days of the date of this Order.

> whether the agency's answer is based on a permissible construction of the statute.

Chevron U.S.A. v. Natural Res. Def. Council, 467 U.S. 837, 842-843 (1983). In upholding an agency's answer, moreover, "[t]he court need not conclude that the agency construction was the only one it permissibly could have adapted to uphold the construction, or even the reading the court would have reached if the question initially had arisen in a judicial proceeding." *Id.* at 843 n.11. Rather, the agency's interpretation is to be given controlling weight unless it is "arbitrary, capricious or manifestly contrary to the statute." *Id.* at 844. With this standard set forth, we now turn to the specific arguments raised by the plaintiffs.

Counts I and II

With respect to Count I of their Complaint, plaintiffs argue that the amended § 360.10 denies them their statutory right, under the Medicare Act, to charge Medicare beneficiaries the remaining cost-sharing amounts and/or to recover their reasonable costs/charges. This right, plaintiffs assert, exists even where the Medicare beneficiary also happens to be eligible under Medicaid.

With respect to Count II, plaintiffs contend that § 360.10 violates the Medicare Act's proscription against cost-shifting, as detailed in 42 U.S.C. § 1395x(v)(1)(A) and 42 C.F.R. § 413.80(d). Section 413.80(d) of title 42 of the Code of Federal Regulations provides:

> Under Medicare, costs of covered services *furnished beneficiaries* are not to be borne by individuals not covered by the Medicare program, and conversely, costs of services provided for other than beneficiaries are not to be borne by the health insurance program. Uncollected revenue related to services rendered to beneficiaries of the program generally means the provider has not recovered the cost of services covered by that revenue. The failure of beneficiaries to pay the deductible and coinsurance amounts can result in the related costs of covered services

> being borne by other than Medicare beneficiaries. (emphasis supplied)

Plaintiffs appear to contend that, by preventing providers from recovering the remaining cost-sharing amounts from either the patient or the state § 360.10 shifts those unpaid costs onto the providers. The unspoken consequence of this scenario is that the providers will either bear the loss or shift the unpaid portions of their costs/charges onto their non-Medicare/Medicaid patients.

We deal with these contentions together because they both rely upon an essential premise: that by purchasing Medicare Part B coverage for its Medicaid recipients, the State has transformed those recipients, for the purpose of provider reimbursement, into Medicare beneficiaries. This premise is integral to plaintiffs' claims because, quite logically, the rights and proscriptions of the Medicare Act upon which they rely apply only to Medicare beneficiaries and their Medicare providers.

Plaintiffs support this premise only cursorily in their Reply Memorandum to this Court in which they state:

> {I}t is clear that the services provided to crossovers are services provided under the *Medicare* program. Payment for such services is {therefore} made, and must be made, pursuant to the Medicare-approved reasonable cost and charges.

Plaintiffs' Reply Memorandum of Law at 9-10 (emphasis in original; footnote omitted). This argument, however, is itself based upon an unsupported premise: that the services a patient receives define that patient's status as a beneficiary and that patient's payment obligations.

In support of its own motion for summary judgment, the Secretary argues that there is nothing in the Medicare Act which makes its reimbursement schedule controlling in the case of a crossover patient. Plantiffs' rebuttal to this—that there is also nothing within the Medicare statute which would preclude application of the Act's policies and proscriptions to crossover patients—does not however, prove plaintiffs' premise. Rather, it merely underscores the absence of any Congressional direc-

tive concerning the treatment of crossovers, one way or the other, for payment purposes. In the absence of any clear Congressional intent on the matter, this Court is therefore relegated to determining whether the Secretary's interpretation of those payment obligations is based upon a permissible construction of the statutes at issue here.

It has been the Secretary's consistent policy, since at least 1971,[11] to treat crossover patients as primarily Medicaid patients. Streimer Affidavit at ¶ 5. In formulating this policy, the Secretary, as well as the state, has taken the position that, with respect to buy-in agreements, Medicare plays the role of a third party payor. Indeed, that position appears to be consistent with the relevant federal implementing regulations and with prior case law on the matter. See 42 C.F.R. § 433.136; *New York State Dept. of Social Services v. Bowen*, 661 F.Supp. 1537, 1551-52 (S.D.N.Y. 1987). It is also a position with which the plaintiffs have no apparent disagreement.[12] Having conceded that point, it is difficult to see how plaintiffs can claim an entitlement to cost-sharing payments directly from the crossovers. After all, the Medicaid Act, 42 U.S.C. § 1396(a)(25)(C), specifically provides that "the person furnishing the service *may not seek to collect from the individual* . . . payment of an amount for that service . . . if the total amount of the liabilities of third parties {*i.e.* Medicare} for that service is at least equal to the amount payable for that service under the {state} plan {*i.e.* Medicaid}." (emphasis supplied).

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11 Policy Information Memorandum No. 6, dated March 4, 1971, states:

> . . . the [state] agency is not necessarily obligated to pay the full amount of the deductibles and coinsurance costs according to the rates established under Title XVIII {Medicare Act}, but only that amount which will satisfy the requirement for payment in full according to the Title XIX {Medicaid Act} method of payment.

Reply Affidavit of Peter F. Nadel, Exhibit C.

12 Rather, plaintiffs argue that these general third party liability provisions cannot be read to implicitly amend 1396(a)(15) which, they contend, imposes upon the state a specific obligation to pay the cost-sharing amounts of crossovers. Plaintiffs' Reply Memorandum at 33-37. We address plaintiffs' arguments with respect to § 1396(a)(15) *infra*.

By forbidding recourse to the beneficiaries, the amendment here challenged merely incorporates this statutory prohibition.

The real target of plaintiffs' claims under the Medicare Act, however, is not the beneficiary, but the state and its Medicaid plan. Plaintiffs' Memorandum at 17. But again, the rules governing payment under third party arrangements do not mandate full payment by the state. Rather, 42 C.F.R. 433.139(b)(1) provides that "[w]hen the amount of [third party] liability is determined, the [state] agency must then pay the claim to the extent that payment allowed under the agency's payment schedule exceeds the amount of the third party's payment." The implicit corollary of this regulation is that the state may, but need not, pay more. Plaintiffs' arguable interpretation of 1396(a)(15) side, moreover, there is nothing in either the Medicare or Medicaid statutes which even remotely suggests that where the state assumes payment of a recipient's Medicare premiums, it also implicitly assumes payment of that beneficiary's cost-sharing amounts.

Plaintiffs' contention that § 360.10 is violative of the Medicare Act's cost-shifting proscription does not stand on firmer ground. Again, plaintiffs make the very sweeping assumption that the policy considerations underlying the Medicare Act are wholly applicable to buy-in agreements. Even if we were prepared to make such an assumption, however, one would necessarily have to hold the additional presupposition that § 395x(v)(1)(A)'s cost-shifting proscription, as plaintiffs characterize it, was intended to protect health care providers and physicians. Yet one need not look beyond the legislative history of that provision and the implementing regulations promulgated thereunder to determine that the intended beneficiaries of this so-called cost-shifting proscription are not health care providers and physicians, but other patients not covered by the Medicare insurance program. While providers and physicians might, as a practical matter, shift those costs onto their non-Medicare patients, that is not an assumption this Court will make in the absence of any evidence or argument by plaintiffs that that is in fact what is occurring. Finally, we note that § 1395x(v) speaks only in terms of "reasonable costs" and can

therefore only be deemed applicable to "providers," not "physicians."[13] With respect to those providers, moreover, 42 C.F.R. § 413.80(a) provides that "bad debts attributable to the unpaid} deductibles and coinsurance amounts are reimbursable under the {Medicare} program." According to the Secretary, such bad debt treatment is available to Medicare providers for their treatment of crossovers. Affidavit of Robert A. Streimer at ¶ 6.[14] Thus, in the face of this regulation, even providers can hardly argue that § 360.10 makes them the victims of cost-shifting.

In upholding the Secretary's interpretation, we do not mean to suggest that plaintiffs' position with respect the buy-in agreements is wholly unsupportable. What plaintiffs fail to come to terms with, however, is that the buy-in agreements reflect a conflation of aspects of two statutes which, in a very fundamental way, are odds with each other. As all parties acknowledge, Medicare is a health insurance program and is intended to be completely self-supporting. On the other hand, Medicaid is a welfare type program intended to provide financial assistance for the medical assistance of needy persons. Under these circumstances, the Secretary's interpretation of the buy-in agreements as third party arrangements represents a permissible construction of the statutes and a reasonable reconciliation of their conflicting nature. It should be noted that, in almost all cases, total reimbursement to providers will be higher than the Medicaid rate of payment and, in some instances, will even be higher than the Medicare rate of payment. *See* Examples, *supra* at 6 n.6.

Count III

Plaintiffs argue that they are entitled to summary on Count III of their complaint, because § 360.10 violates Section

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13 Physicians are reimbursed on the basis of their "reasonable charge{s}." 42 U.S.C. § 13951(a)(1).

14 I.E., although § 360.10 prohibits providers from charging either the patient or the state for unpaid deductibles and coinsurance funds, it does not prevent them from attempting to receive that money from the *federally* funded Medicare program.

1902(a)(15) of the Social Security Act, codified at 42 U.S.C. § 1396a(a)(15), which they argue requires the states to pay cost sharing amounts in full.[15] Section 1396a(a)(15) {hereinafter a-15} 1 reads in relevant part that a Medicaid plan must:

> {I}n the case of eligible individuals 65 Years or older who. . . are covered by either or both of the insurance programs established by subchapter XVIII{Medicare} of this chapter, provide where, under the plan, all of any deductible, cost sharing, or similar charge imposed with respect to such individual under the insurance program established by such subchapter is not met, the portion thereof which is met shall be determined on a basis reasonably related (as determined in accordance with standards approved by the Secretary and included in the the plan) to such individual's income or his income and resources.

Defendants argue that the Secretary has, for a long time, taken the position that a-15 does not require Medicaid to pay Medicare cost-sharing in amounts which would result in providers being reimbursed for a total amount greater than the Medicaid level. Plaintiffs argue that this is an arbitrary and capricious reading of the language. They argue that cost-sharing must be paid in full, by the individual according to his/her income or resources, and the balance by the state.

Defendants point out the fact that a-15 does not explicitly require that providers be paid cost-sharing in full. They argue that *when* a state plan provides for dually eligible individual's to pay a portion of the cost-sharing, that portion must be determined on a basis reasonably related to the *individual's* income and resources. Defendants argue that a-15 was intended, therefore, to protect the interests of the beneficiary, and to insure that already needy beneficiaries are not required to spend, in essence, money that they have already been determined (by

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15 As dicussed on page 8, *supra*, since the commencement of this litigation, § 1396a(a)(15) has been repealed, so discussion of the effect of that section applies only to the situation prior to July 1, 1989, the date on which the repeal became effective.

their eligibility for Medicaid), not to have for medical care. *Defendant Perales' Memorandum of Law in Opposition at 32-35*. Defendants point out that this interpretation of a-15 has been accepted as reasonable in other courts. *See Samuel v. California Department of Health Services*, 570 F.Supp. 566 (N.D.Cal. 1983). The plausibility of defendants' interpretation is somewhat dependent upon the plausibility of their argument that crossover patients are treated by them primarily as Medicaid (and therefore needy), as opposed to Medicare patients. As discussed, *supra*, defendants have demonstrated to this court's satisfaction that that has, indeed, been the Secretary's policy. Again, these regulations are complicated, ambiguous, and often apparently conflicting. Defendants' interpretation of a-15 is a rational interpretation, and while other interpretations may also be rational, it would not be appropriate for this Court to overturn the defendants' rational policy.

Conclusion

Therefore, for the reasons discussed, *supra*, plaintiffs' motion for summary judgment on Counts I-III is denied, and defendants' motions under Fed.R.Civ.Pro.12(b)(6) and 56 are granted.

It Is So Ordered.

UNITED STATES DISTRICT JUDGE

Dated: New York, New York
, 1991

UNITED STATES COURT OF APPEALS
FOR THE
SECOND CIRCUIT

FILED MAY 20, 1992

DOCKET NUMBER: 91-6123

At a stated term of the United States Court of Appeals for the Second Circuit, held at the United States Courthouse in the City of New York, on the 20th day of May one thousand nine hundred and ninety-two.

NYC HEALTH & HOSP. V. PERALES ET. AL.

A petition for rehearing containing a suggestion that the action be reheard in banc having been filed herein by Appellee LOUIS W. SULLIVAN

Upon consideration by the panel that decided the appeal, it is

Ordered that said petition for rehearing is DENIED.

It is further noted that the suggestion for rehearing in banc has been transmitted to the judges of the court in regular active service and to any other judge that heard the appeal and that no such judge has requested that a vote be taken thereon.

/s/ ELAINE B. GOLDSMITH
Clerk

RELEVANT STATUTES AND REGULATION

18 N.Y.C.R.R. § 370-7.7

The challenged regulation, codified at 18 N.Y.C.R.R. § 370-7.7, provided as follows:

(a) The MA [Medicaid] program will pay on behalf of MA recipients, including qualified Medicare beneficiaries defined in subdivision (g) of this section, the amount of any deductible or coinsurance liability incurred under Part A of Title XVIII of the Social Security Act.

(b) (1) Except as otherwise provided in paragraph (2) of this subdivision, the MA program will pay on behalf of MA recipients, including qualified Medicare beneficiaries, the amount of any deductible or coinsurance liability incurred under Part B of Title XVIII of the Social Security Act if the Medicare Part B payment is less than the established MA fee. The MA program will pay only the difference between the Medicare Part B payment and the lower of the MA fee or the Medicare approved amount.

(2) The MA program will pay on behalf of MA recipients, including qualified Medicare beneficiaries, the full amount of any deductible or coinsurance liability incurred for ambulance services provided under Part B of Title XVIII of the Social Security Act.

(c) Before the MA program will pay any Medicare Part B deductible or coinsurance liability, the MA recipient or qualified Medicare beneficiary must assign to the provider any Part B benefit payment to which he or she is entitled. A provider of a Medicare Part B benefit must accept assignment from such recipient or beneficiary of his or her right to receive the Medicare Part B payment.

(d) A provider of a Medicare Part B benefit must not seek to recover any Medicare Part B deductible or coinsurance

amounts from an MA recipient or qualified Medicare beneficiary.

(e) To be paid for transportation services that are not paid through the Medicaid Management Information System, a provider must submit to the social services district bills for deductible and coinsurance amounts and the explanations of benefits form issued by the Medicare carrier. A provider does not have to submit the explanation of benefits form to a district which can obtain this information from the Medicare part B fiscal agent's computer files. A district must apply Medicare part B benefits before making MA payments for claims.

(f) Reimbursement is not available under the MA program for services or supplies furnished pursuant to title XVIII of the Social Security Act (Medicare) if:

(1) the provisions of such title or the regulations promulgated to implement such title preclude a provider of such services or supplies form charging a Medicare beneficiary for the cost of the supplies or services provided; or

(2) the provider agrees, under the terms of a Medicare provider agreement, not to charge an individual for the cost of services or supplies.

(g) *Qualified Medicare beneficiaries.* (1) As used in this section and section 360-7.8 of this Subpart, the term *qualified Medicare beneficiary* means a person:

(i) who is entitled to hospital insurance benefits under Medicare Part A;

(ii) whose income does not exceed 100 percent of the poverty line, as defined in section 360-1.4 of this Part, applicable to a family of the size involved;

(iii) whose resources do not exceed twice the maximum amount of resources that the person may have to be eligible for Supplemental Security Income benefits; and

(iv) who meets the nonfinancial eligibility requirements contained in Subpart 360-3 of this Part.

(h) *Qualified Disabled and Working Individuals.* As used in this section and section 360-7.8 of this Subpart, the term *qualified disabled and working individuals* means a person who is not otherwise eligible for medical assistance and:

(1) who is entitled to a hospital insurance benefits under Section 1818A of Part A of Title XVIII of the Social Security Act;

(2) whose income does not exceed 200 percent of the official federal poverty line applicable to the person's family size; and

(3) whose resources do not exceed twice the maximum amount of resources that an individual or a couple, in the case of a married individual, may have and obtain federal supplemental security income benefits under Title XVI of the federal Social Security Act, as determined for purposes of that program.

The challenged regulation, as originally promulgated and codified at 18 N.Y.C.R.R. §360.10, provided as follows:

(a) Medical assistance [*i.e.*, Medicaid payments] shall include the amount of any deductible or coinsurance liabilities under Part A of Title XVIII of the Social Security Act (Medicare) for all eligible applicants or recipients.

(b) Medical assistance shall include the amount of any deductible or coinsurance liabilities under Medicare Part B for all eligible applicants or recipients to the extent that:

(1) When the Medicare payment to a provider of a Part B benefit is less than the established medical assistance fee or rate for the benefit, the Department shall pay the provider an amount equal to the difference between the Medicare Part B payment and the lower of:

(i) the established medical assistance fee or rate; or

(ii) the Medicare approved amount.

(2) When the Medicare payment to a provider of a Part B benefit equals or exceeds the established medical assistance fee or rate for the benefit, the Department shall pay no Part B coinsurance or deductible amounts to the provider.

(c) The Department shall require, as a condition of medical assistance payment of the amount of any Medicare Part B deductible or coinsurance, that the client make an assignment to the provider of any Part B benefit payments to which the client is entitled.

(d) Providers of care, services, supplies or equipment covered under Medicare Part B and the medical assistance program shall accept assignment of a person's right to receive Medicare Part B payments and shall not seek to recover Medicare Part B deductible or coinsurance amounts from such person if such person is also eligible for medical assistance.

(e) To be paid for transportation services that are not paid through the Medicaid Management Information System, providers shall submit to local districts bills for deductible and coinsurance amounts and the explanations of benefits form issued by the Medicare carrier. Providers do not have to submit the explanation of benefits form to districts that may obtain this information from the Medicare Part B fiscal agent's computer files. Districts must apply Medicare Part B benefits before making medical assistance payments for claims.

Medicare Act

42 U.S.C. § 1395cc(a)(2)(A) provides, as follows:

A provider of services may charge such individual or other person (i) the amount of any deduction or coinsurance amount imposed pursuant to section 1395e(a)(1), (a)(3), or (a)(4), section 1395l(b), or section 1395x(y)(3) of this title with respect to such items and services (not in excess of the amount customarily charged for such items and services by such provider), and (ii) an amount equal to 20 per centum of the reasonable charges for such items and services (not in excess of 20 per centum of the amount customarily charged for such items and services by such provider) for which payment is made under par B of this subchapter or which are durable medical equipment furnished as home health services (but in the case of items and services furnished to individuals with end-stage renal disease, an amount equal to 20 percent of the estimated amounts for such items and services calculated on the basis established by the Secretary). . . .

Medicaid Act

42 U.S.C. § 1396a(a)(10)(E)(i) provides in relevant part that a State Medicaid plan must provide "for making medical assistance available for medicare cost-sharing . . . for qualified medicare beneficiaries . . ."

Section 1396a(n) provides:

(n) Payment amount

In the case of medical assistance [*i.e.*, Medicaid] furnished under this title for medicare cost-sharing respecting the furnishing of a service or item to a qualified medicare beneficiary, the State plan may provide payment in an amount with respect to the service or item that results in the sum of such payment amount and any amount of payment made under subchapter XVIII of this chapter.

Former Section 1396a(a)(15) provided that a state Medicaid plan must:

> in the case of eligible individuals 65 years of age or older who are . . . covered by either or both of the insurance programs established by title XVIII, provide where, under the plan, all of any deductible, cost sharing, or similar charge imposed with respect to such individual under the insurance program established by such title is not met, the portion thereof which is met shall be determined on a basis reasonably related (as determined in accordance with standards approved by the Secretary and included in the plan) to such individual's income or his income and resources.

Congress repealed 42 U.S.C. § 1396a(a)(15) on October 13, 1988, effective July 1, 1989. Pub. L. No. 100-360, § 301(e)(2)(C), 102 Stat. 683, 749, as amended by Pub. L. No. 100-485, § 608(d)(14)(I)(iii), 102 Stat. 2343, 2416.

SUPREME COURT, U.S.
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No. 92-315

IN THE

SUPREME COURT OF THE UNITED STATES

October Term, 1992

CESAR A. PERALES, as Commissioner of Social Services of the State of New York,

Petitioner,

v.

NEW YORK CITY HEALTH AND HOSPITALS CORPORATION, MEDICAL SOCIETY OF THE STATE OF NEW YORK, SIDNEY FINKEL, JOHN A. BLESKI and LOUIS W. SULLIVAN, as Secretary of the United States Department of Health and Human Services,

Respondents.

BRIEF OF RESPONDENTS NEW YORK CITY HEALTH AND HOSPITALS CORPORATION, MEDICAL SOCIETY OF THE STATE OF NEW YORK, FINKEL AND BLESKI IN OPPOSITION TO A PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SECOND CIRCUIT

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QUESTION PRESENTED

Are states required to pay Medicare coinsurance and deductible amounts in full on behalf of persons dually eligible for Medicare and Medicaid benefits and other "qualified medicare beneficiaries"?

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No. 92-315

IN THE

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October Term, 1992

CESAR A. PERALES, as Commissioner of Social Services of the State of New York,

Petitioner,

v.

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Respondents.

BRIEF OF RESPONDENTS NEW YORK CITY HEALTH AND HOSPITALS CORPORATION, MEDICAL SOCIETY OF THE STATE OF NEW YORK, FINKEL AND BLESKI IN OPPOSITION TO A PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SECOND CIRCUIT

Respondents New York City Health and Hospitals Corporation, Medical Society of the State of New York,[1] Sidney Finkel and John A. Bleski oppose the Commissioner of Social

1. There are no parent or subsidiary companies of New York City Health and Hospitals Corporation or Medical Society of the State of New York to be listed pursuant to Supreme Court Rule 29.1.

Services of the State of New York's Petition for a Writ of Certiorari to review the judgment of the United States Court of Appeals for the Second Circuit.

STATEMENT OF THE CASE

This case involves the elimination by New York State, effective January 1, 1987, of the statutory rights of health care providers to receive certain payments for services rendered to persons dually eligible for Medicare and Medicaid benefits ("dual eligibles" or "crossovers") and other "qualified medicare beneficiaries" ("QMBs"), a category of Medicare beneficiaries with income and resources below federal poverty levels.

The payments here at issue are Medicare "cost-sharing" amounts: the annual deductible and 20% coinsurance portion of the Medicare-approved reasonable costs or charges for which the Medicare-eligible patient remains personally liable. Historically, the New York Medicaid Program reimbursed providers for such cost-sharing amounts on behalf of dual eligibles. Effective January 1, 1987, New York State amended its Regulations so as to (i) eliminate or drastically reduce all such Medicaid reimbursement for the Medicare cost-sharing amounts, and (ii) prohibit providers from seeking to recover such amounts from dual eligibles. These Regulations were later amended to extend the same payment limitation to other QMBs.

The Court of Appeals correctly held that federal law entitles providers to receive full payment of the cost-sharing amounts attributable to dual eligibles and other QMBs.

The Medicare Program

In 1965 Congress established the Medicare Program as Title XVIII of the Social Security Act, 42 U.S.C. §§1395-1395ccc. Medicare is a purely federal program which provides reimbursement for medical care to the aged and certain disabled persons.

There are two components to the Medicare Program. Part A (which is not involved in this case) provides hospital insurance benefits and is financed by Social Security payroll contributions. 42 U.S.C. §§1395c-1395i-4. Part B is a voluntary supplementary

program for Medicare-eligibles who choose to enroll, which pays for certain physician services, hospital outpatient services, and other health services generally not covered under Part A. 42 U.S.C. §§1395j-1395w-4(j). The beneficiary is required to pay an enrollment premium and an annual deductible for services covered under Part B. Above this deductible amount, Medicare pays 80% of the "reasonable costs" in the case of services provided by a hospital, and 80% of the "reasonable charges" for physician services, as those costs and charges are calculated and established pursuant to the Medicare Act and Regulations. The beneficiary is responsible for the remaining 20% coinsurance amount.

Providers are entitled to receive *full* reasonable costs and charges for *all* services provided to *all* Medicare beneficiaries. 42 U.S.C. §1395*l*; 42 C.F.R. §§405.501, 410.150, 410.152. This entitlement is fulfilled through the 80% Medicare payment and the beneficiaries' payment of the "cost-sharing" amounts – the deductible and 20% coinsurance.

The Medicaid Program

Concurrently with the enactment of Medicare in 1965, Congress established the Medicaid program as Title XIX of the Social Security Act, 42 U.S.C. §§1396, *et seq.*, to provide federal financial assistance to states that choose to reimburse the costs of medical care for needy persons. To qualify for federal matching funds, states participating in the Medicaid program must have a state plan that has been approved by the Secretary of Health and Human Services (the "Secretary") as conforming with federal requirements. 42 U.S.C. §§1396a(a), 1396a(b).

Payment rates for services provided under the Medicaid program are established by the states and are generally not based on the "reasonable cost" or "reasonable charge" standards that govern payment under Medicare. New York State has established Medicaid reimbursement rates that are (i) in all cases lower than the "reasonable cost" or "reasonable charges" established by Medicare Part B for the same services and (ii) in almost all cases lower than the Medicare payment of 80% of such "reasonable cost" or "reasonable charges."

QMBs and Dually Eligible Individuals

In order to assure full and equal access to health care services and provide for full payment of Medicare reasonable costs and charges for *all* Medicare beneficiaries, Congress specifically addressed the situation of the elderly poor who could not afford the Part B enrollment premiums or pay the cost-sharing amounts.

Thus, from inception in 1965, (i) the Medicare Act permitted states to enroll the poorest of the Medicare beneficiaries – those also eligible for Medicaid – in the Part B program by entering into a "buy-in" agreement with the Secretary and paying the premiums on their behalf, and (ii) the Medicaid Act expressly required that state Medicaid programs assume crossovers' obligation to pay *all* Medicare deductibles and coinsurance amounts except that the states could elect to have a portion thereof paid by the individual on a basis reasonably related to his means. 42 U.S.C. §1396a(a)(15) [repealed] ("(a)(15)"). For services furnished to dual eligibles, the Medicaid Act (42 U.S.C. §1396b(b)(1)) and the Secretary's Regulations (42 C.F.R. §431.625(d)(3)) also provide that payment is to be made pursuant to the *Medicare* reasonable costs and charges rather than pursuant to the rates set under each state's Medicaid program.

The Omnibus Budget Reconciliation Act of 1986 (P.L. 99-509, 100 Stat. 1874, 2053-54) expanded this protection for the elderly poor by creating QMBs as a sub-category of Medicare beneficiaries whose incomes and resources were below federal poverty levels, but who were not poor enough to qualify for Medicaid. States were given the option to pay cost-sharing for this new QMB group under the states' Medicaid programs (thereby qualifying for federal matching funds). P.L. 99-509, §9403(a), 100 Stat. 1874, 2053, adding subparagraph (E) to 42 U.S.C. §1396a(a)(10).

The Medicare Catastrophic Coverage Act of 1988, P.L. 100-360, 102 Stat. 683, made two changes concerning QMBs and cost-sharing. First, Congress made it mandatory that state Medicaid programs pay for QMBs' cost-sharing liability. P.L. 100-360, §301(a)(1), 102 Stat. 683, 748 (amending §1396a(a)(10)(E) to delete

the phrase "at the option of a state"). Second, the definition of QMB was broadened to include all Medicare-eligible individuals with incomes below federal poverty levels, whether or not those individuals were also eligible for Medicaid. *See* §8434(a) of the Technical and Miscellaneous Revenue Act of 1988, P.L. 100-647, 102 Stat. 3342, 3805. Thus, although the crossover provision — §1396a(a)(15) — was repealed effective July 1, 1989[2], the obligation of states to pay Medicare cost-sharing in full was continued and made uniform for crossovers and other QMBs through §1396a(a)(10)(E) ("(a)(10)(E)"), discussed below (pp. 9-12 *infra*).[3]

The New York Regulation

In accordance with these requirements, until January 1, 1987, New York paid the full cost-sharing amounts on behalf of crossover beneficiaries. Effective January 1, 1987, the New York State Department of Social Services amended its Regulation 18 N.Y.C.R.R. §360.10 to reduce or eliminate Medicaid payments of cost-sharing amounts for Medicare Part B services.[4] As it relates to this action, the State Regulation permits payment by the New York Medicaid program of QMBs' Medicare Part B cost-sharing obligations only to the extent that the amount paid by the State, plus the 80% Medicare payment of the reasonable cost or charge, does not exceed the level of reimbursement established by the Medicaid fee schedule. For most Part B

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2. *See* P.L. 100-360, §301(e)(2)(C), 102 Stat. 683, 749, as amended by §608(d)(14)(I) of the Family Support Act of 1988, P.L. 100-485, 102 Stat. 2343, 2416.

3. The QMB coverage provisions were initially made optional, rather than mandatory, because "the Committee recognizes that the fiscal constraints facing many states may preclude" more comprehensive coverage. H.R. Rep. No. 727, 99th Cong., 2d Sess., *reprinted in* 1986 U.S. Code Cong. & Ad. News 3607, 3696. The cost-sharing option was made mandatory two years later, notwithstanding these fiscal constraints.

4. Effective March 1, 1989, Section 360.10 was amended without substantive change and recodified as 18 N.Y.C.R.R. §360-7.7. The payment limitation therein was extended to apply to QMBs effective March 21, 1990. N.Y. St. Reg., April 11, 1990, p. 47. Sections 360.10 and 360-7.7 are referred to herein as the "New York Regulation" or "State Regulation."

services, the 80% Medicare payment exceeds the corresponding Medicaid rate for the service. Thus, in most cases the State now pays no part of the Part B cost-sharing amounts.

The Decision Below

The Court of Appeals for the Second Circuit held (Pet. App. 1a-20a) that the New York Regulation violated (i) the Medicaid Act requirement that states pay the full cost-sharing amounts on behalf of crossovers and other QMBs and (ii) the Medicare Act provisions entitling providers to full payment of their reasonable costs and charges for all services, including Part B services, provided to all Medicare beneficiaries, including crossovers and other QMBs. Because it found the statutes to be unambiguous and complete on the specific issue presented, it refused to defer to the Secretary's contrary position. (Pet. App. 9a, 16a-20a.)

All of the active judges of the Second Circuit considered and rejected a petition for rehearing and suggestion for rehearing *en banc*, which set forth all of the arguments here presented. No judge voted in favor of the petition. (Pet. App. 49a.)

REASONS FOR DENYING THE WRIT

This case presents none of the requisite "special and important reasons" (Sup. Ct. Rule 10) for granting a Petition for Certiorari. There is no conflict among the Courts of Appeals or with a state court of last resort; there has been no "depart[ure] from the usual course of judicial proceedings"; no federal question has been decided in a way that conflicts with decisions of this Court; and no question of federal law is presently at stake "that should be settled by this Court." *Id.* Moreover, the Secretary, whose approval of the New York Regulation was invalidated by the Second Circuit, did not seek Certiorari and did not submit a brief in support of the State's Petition, as permitted by Supreme Court Rule 12.4.

In the absence of any recognized basis to support the Petition for Certiorari, Petitioner mischaracterizes the Court of Appeals decision and the applicable provisions of the Medicare and Medicaid Acts so as to create the illusion of a "significant and

unresolved issue of statutory and regulatory interpretation" (Pet. 8) – some "gap" to be filled in by administrative interpretation. Thus the argument (Pet. 9) that review of the decision "will provide this Court with the opportunity to further define the *Chevron* standard." (*See Chevron U.S.A. v. Natural Resources Defense Council*, 467 U.S. 837 (1984).)

Supreme Court Rule 15.1 requires us to address misstatements of fact or law set forth in the Petition. There are several. Most significantly, the Petition fails to cite, quote or address the central Medicaid Act provision that conclusively establishes the states' obligations to pay Medicare cost-sharing in full for crossovers and other QMBs.

The Medicare cost-sharing that Section 1396a(a)(10)(E) requires the states to pay on behalf of QMBs is defined (in 42 U.S.C. §1396d(p)(3)) as including *all* Medicare Part B premiums, coinsurance, and deductibles. Cost-sharing is specifically defined ((p)(3)(D)) (Appendix A-1) to include

> "the difference between the amount that is paid under section 1395*l*(a) of this title [*i.e.*, 80% of the reasonable costs and charges for covered Part B services] and the amount that would be paid under such section if any reference to '80 percent' therein were deemed a reference to '100 percent.' "

The statute thus specifies payment of the "difference between 80% and 100%" and there is no room to defer to the Secretary's interpretation: the "difference between 80% and a state's Medicaid rate."

As shown below, there is no *Chevron* issue to be addressed. The Medicare and Medicaid Acts may be complicated (Pet. 8), but as the Court of Appeals determined, "complexity is not the same as ambiguity." (Pet. App. 19a.) The Court correctly noted that the statute is neither ambiguous nor silent as to the question whether states must pay QMBs' Medicare Part B cost-sharing in full (Pet. App. 17a). Petitioner's attempt to create ambiguity by mischaracterizing the Act and the decision below must fail.

A. Ambiguity, Deference And The *Chevron* Standard

The deference that *Chevron* commands can only be accorded when there is a need "'to fill any gap left, implicitly or explicitly, by Congress.'" 467 U.S. at 843, quoting *Morton v. Ruiz*, 415 U.S. 199, 231 (1974). Petitioner disingenuously attempts to create such a gap by stating that the Court of Appeals "relied principally upon its interpretation of section 1395cc(a)(2)(A) of the *Medicare* Act and legislative history applicable primarily to Medicare Part A" in concluding that states were required to pay Medicare Part B cost-sharing in full on behalf of QMBs (Pet. 8, emphasis in original). In fact, as shown below, the Court of Appeals relied not only on §1395cc(a)(2)(A), but on other provisions of the *Medicaid* Act — provisions that Petitioner virtually ignores — that clearly and unambiguously require states to pay QMBs' Medicare Part B cost-sharing in full.

1. The Statutory Requirement of Payment in Full

Section 1395cc(a)(2)(A) states that providers are entitled to charge the 20% coinsurance for covered services furnished to Medicare beneficiaries (*see* Pet. App. 54a).[5] Because that provision does not specify "Medicare beneficiaries, *including dual eligibles and other QMBs*" Petitioner argues that the provision is ambiguous, thus enabling him to read into it a *sub silentio* exception for dual eligibles and other QMBs. With equal fervor it could be asserted that the statute is ambiguous because it does not expressly state "all Medicare beneficiaries, including New York residents."

There is, however, no statutory gap or conflict with respect to these beneficiaries or services. The Medicare Act (including §1395cc(a)(2)(A)) requires, by its terms, payment of full reasonable costs and charges for *all* services to *all* Medicare patients. These provisions are absolute and exceptions thereto are nowhere articulated. There is no basis for engrafting the exceptions urged

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5. Other provisions of the Medicare Act and Regulations establish providers' right to receive full payment of their reasonable costs or charges. 42 U.S.C. §1395*l*; 42 C.F.R. §§405.501, 410.150, 410.152.

by the Petitioner: "all Medicare patients except crossovers/QMBs" or "all services except Part B services for crossovers/QMBs."

To the contrary, Congress specifically intended the reasonable costs and charges provisions to apply to crossover/QMB services. At the *very same time* that Congress created Medicare in 1965, it provided in the parallel Medicaid Act ((a)(15)) that states were obliged to pay the Medicare coinsurance amounts for crossovers. And the states were so obliged for the *very reason* that the elderly poor could not pay themselves and Congress wanted them to have full and equal access to all Medicare services. That is why the Medicare reasonable cost/charge provisions contain no express exception: none was intended. The states would pay on behalf of crossovers – and later for QMBs under (a)(10)(E) – and full reasonable costs/charges would thereby result.[6]

Wholly apart from the Medicare Act requirements and wholly apart from whether these patients can be characterized as "primarily Medicaid" or "primarily Medicare," the specific requirements of (a)(15), (a)(10)(E) and 1396d(p)(3) control. *These* provisions are surely not "silent or ambiguous with respect to the specific issue." There is thus no *Chevron* issue to be addressed.

Finally, Petitioner (again ignoring (a)(15), (a)(10)(E) and 1396d(p)(3)) cites §1396a(n) as the "section of the Medicaid Act [that] deals specifically with payment for services to QMBs . . . ." (Pet. 9.) But as the Court of Appeals found, this provision, which stipulates that states "may" pay more than the Medicaid rate for QMBs' cost-sharing, cannot be stretched into

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6. Petitioner's statement (Pet. 8) that there is an "absence of express language" elsewhere in the *Medicare* Act supporting the conclusion that states must pay QMBs' cost-sharing in full is both literally true and quite misleading: Sections (a)(15), (a)(10)(E) and 1396d(p)(3) of the *Medicaid* Act clearly provide for state payment in full of QMBs' Medicare cost-sharing. (The text of Section (a)(15) can be found at Pet. App. 55a; Sections (a)(10)(E) and 1396d(p)(3) are set forth in the Appendix to this brief, p. A-1)

an *implicit* option to pay less than the full cost-sharing *expressly* required by (a)(10)(E) and §1396d(p)(3).[7]

2. Payment in Full for Part B Services

Petitioner concedes (Pet. 9-10) and the Dissent acknowledged (Pet. App. 27a), that Congress intended Part A cost-sharing to be paid by the states for crossovers/QMBs, but not Part B. The recognition that states must pay Part A cost-sharing in full necessarily leads to the conclusion that Part B cost-sharing must also be paid in full: the Medicaid Act makes no distinction in terms of its compulsion. Significantly, Petitioner can point to no provision in the statutes that specifies such a Part B exception to the states' obligation to pay Medicare cost-sharing.

Initially, there were, indeed, different Part A/Part B requirements for state payment of cost-sharing. But the different requirement chosen by Congress was not that suggested by Petitioner and, in any event, was *obliterated in 1968*, when the states' obligations were made uniform for both Part A and Part B.

As originally enacted in 1965, (a)(15) required the states to pay Part A cost-sharing in full, but where "all" of the Part B cost-sharing was not paid by the state, the amount paid had to be determined in accordance with the beneficiaries' means. *See* Social Security Amendments of 1965, Pub. L. 89-97, §121(a), 70 Stat. 286. Thus, some small portion of the state's obligation could be imposed on the beneficiary for Part B, but not Part A

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7. Section 1396a(n) simply makes clear that the general Medicaid provisions that in effect provide that states "may not" pay, and providers "may not" receive, more than the Medicaid rate for treating Medicaid patients cannot be read as limiting a State's cost-sharing obligations in the case of QMBs. Indeed, Petitioner here suggests (Pet. 3, 10-11) that those very Medicaid provisions – §§1396a(a)(25), 1396h(d) and 42 C.F.R. §447.15 – still limit the State's obligation to its Medicaid rate, notwithstanding that §1396a(n) provides that those limitations may be exceeded for crossovers and other QMBs. The State "may" pay more by virtue of §1396a(n) and *must* pay more – the difference between 80 percent and 100 percent – by virtue of (a)(10)(E) and §1396d(p)(3).

services. That was the distinction drawn by Congress and the only distinction.[8]

Congress eliminated this difference in 1968 by also permitting some portion of the Part A coinsurance obligation to be imposed on the beneficiaries. *See* Social Security Amendments of 1967, Pub. L. 90-248, §235(a)(3), 81 Stat. 821. The states' obligations were thereafter identical for both Part A and Part B coinsurance amounts. There is no basis to conclude that in amending the statute, Congress intended to change from explicitly commanding states to pay dual eligibles' Part A cost-sharing in 1965 to permitting the states to pay nothing at all in 1968. Rather, as (a)(15) expressly provides, the states could limit their obligation only to the extent that the beneficiaries could afford to assume a portion of the costs – for both Part A and Part B services.

Nor is any Part A/Part B distinction found in the QMB legislation. To the contrary, those provisions expressly address and require the states to pay Part B cost-sharing on behalf of QMBs. As noted, Section (a)(10)(E) requires states to make "medical assistance available for medicare cost-sharing (as defined in section 1396d(p)(3)," which definition includes all Part A *and* Part B cost-sharing amounts: specifically enumerated are Part A premiums, *Part B* premiums, Part A and *Part B* Medicare coinsurance, Part A deductibles, *Part B* deductibles and, most significantly, "the difference between 80 percent and 100 percent."

There is, accordingly, no basis to distinguish between states' cost-sharing liability for Part A and Part B services. If, as

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8. Thus, because under the original (a)(15) states could either pay Part B cost-sharing in full or impose a portion of the cost-sharing liability on the dual eligible according to his means, the 1965 Senate Report stated that a state plan "*may* provide for the payment in full of any [cost-sharing]" or that it could require the individual "to share in the cost." S. Rep. No. 404, 89th Cong., 1st Sess., *reprinted in* 1965 U.S. Code Cong. & Ad. News 1943, 2020 (emphasis added). There is no ambiguity here: payment of the full cost is required for both Part A and Part B services, and as to the latter, some share of the liability can be imposed on the individual. Ambiguity can only be created if attention is selectively focused on isolated words (*e.g.*, "may") taken out of context (*see* Pet. 10).

Petitioner acknowledges, it would be arbitrary to differentiate between crossovers/QMBs and other Medicare patients for Part A, and Congress has explicitly commanded full payment for Part A, the same conclusion necessarily follows for Part B since at least 1968 when all differences were removed.

Congress was surely not "silent" on the "specific issue" – the *Chevron* standard for according deference – of Part B coinsurance for crossovers/QMBs. Nor was it ambiguous: the states must pay all Medicare cost-sharing and specifically the difference between "80 percent" and "100 percent" of the Part B reasonable costs/charges. There is no room for doubt or basis to defer to the Secretary's contrary interpretation (the difference between "80 percent and the Medicaid rate").

As *Chevron* instructs (467 U.S. at 842-43), "If the intent of Congress is clear, that is the end of the matter; for the court, as well as the agency, must give effect to the unambiguously expressed intent of Congress." Here, Congress has not been silent on the specific issue of Part B coinsurance. It has spoken and expressed its intent unambiguously in the statutory words used. New York *must* pay the difference between "80 percent" and "100 percent" and, as *Chevron* mandates, "that is the end of the matter." The Court below correctly applied the *Chevron* deference standard and no occasion is presented for this Court "to further define" that standard.

Petitioner nevertheless repeatedly suggests (Pet. 3, 10, 11) that treatment of crossovers as Medicaid patients is appropriate because they "are only enrolled in the Medicare program by the states by virtue of their status as Medicaid recipients" (Pet. 10), and that New York can simply terminate enrollment in Part B or stop paying premiums. But the statute makes enrollment and payment mandatory. Petitioner's characterization of crossovers as "primarily Medicaid patients" is simply an invention without substance or basis, and does not take into account the many QMBs who are not even eligible for Medicaid.[9]

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9. A related argument cannot be taken seriously: Petitioner argues that the Court of Appeals decision provides a "windfall" for treating dual eligibles and a "two-tiered, unequal Medicaid reimbursement scheme, one for Medicaid-eligible only, and another higher level for Medicaid-eligible who

The other arguments asserted in support of the Petition (that the Court of Appeals decision has "national significance," contains a "comprehensive analysis" of the legal positions, and has "immediate and drastic fiscal consequences for New York") take less time to address.

B. "National Significance"

Petitioner argues (Pet. 7, 11) that because the Secretary has approved payment limitations in some 30 other states that are said to be "similar to" the invalidated New York Regulation, the decision has "national significance" and should be reviewed by the Supreme Court. But the same could be said of virtually every court decision involving the Medicare and Medicaid programs, both of which are national in scope. Any decision invalidating the Secretary's program policies could be said to have "national significance," but that alone should not be a basis for granting certiorari, particularly where, as here, the Secretary — who administers the programs at the national level — has not petitioned this Court for a Writ of Certiorari and has not filed a brief in support of the State's Petition.

C. "Comprehensive Analysis of the Issues"

Petitioner's argument (Pet. 8) that the Second Circuit decision contains a "comprehensive analysis" of the legal issues presented, in fact, supports the position that the Petition should be denied. The decision is thorough, comprehensive, and above all, correct, and there is thus no error for this Court to redress.

Although Petitioner refers to "similar" payment limitations in other states, there is nothing in the record concerning such payment limitations or the extent to which they might be similar to the New York limitation at issue here. They may be broader (or narrower) than New York's, and more appropriate for

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also happen to be Medicare eligible." (Pet. 11.) But the point is that Congress determined to avoid two classes of *Medicare* beneficiaries based on wealth, as the Court of Appeals found: "Congress sought to avoid a wealth-based, two-tiered system of health care for the elderly and certain disabled" by assuring providers of reasonable cost/charge reimbursement — "even when that provider is treating a Medicare patient who happens also to be poor." (Pet. App. 11a; 13a.) Moreover, what do Medicaid rates have to do with those QMBs who are not even eligible for Medicaid?

Supreme Court review (if at all) after the lower courts have considered and ruled on such limitations.

For example, the New York Regulation applies only to Part B cost-sharing. The Dissent below and Petitioner here agree that the New York payment limitation, if applied to Part A services, would be unlawful (Pet. 9-10; Pet. App. 27a), but, on information and belief, some states, at the urging of the Secretary, have limited payment of cost-sharing for Part A as well as Part B services.

It should further be noted that the Secretary intends to publish regulations implementing the (a)(10)(E) requirement that states pay QMBs' Medicare cost-sharing, but has not done so to date. Those regulations, when published, would "require states to include in their State plans payment of Medicare cost-sharing for low income Medicare beneficiaries" and would "propose requirements and options for payment amounts and limitations . . . ." 57 Fed. Reg. 16759, 16765 (April 27, 1992). Thus, the Secretary has under active consideration issues at the very heart of this case.

The Second Circuit decision was comprehensive (and correct) as to the issues before it, but important related questions remain to be considered and, perhaps, litigated. By waiting for future cases and the adoption of federal regulations, the Court might have the benefit of a more thorough delineation of the issues.

D. "Drastic and Immediate Fiscal Consequences"

Petitioner's complaint (Pet. 8) of "immediate and drastic" fiscal consequences of the Court of Appeals decision is disingenuous. Petitioner was entitled, pursuant to Fed. R. App. P. 41(b), to move to stay the issuance of the mandate in the Court of Appeals pending a petition for certiorari, and chose not to do so. Moreover, Petitioner waited until the last day to file his Petition. Surely if the fiscal consequences were as immediate and drastic as Petitioner asserts, he would have sought to stay the mandate and would have promptly sought review in this Court. Petitioner should not be allowed to forego available remedies and then use the consequences thereof as a basis for seeking Certiorari.

Moreover, while the decision may cost the State a significant amount of money, these were amounts that until 1987 were paid in full by the State. From the inception of the Medicare and Medicaid programs in 1965 until January 1, 1987, *New York paid in full the Medicare cost-sharing amounts here at issue.* The decision thus does nothing more than restore the *status quo ante* by reinstating the State's pre-1987 policy.

In any event, neither budget constraints, nor the Medicaid Act's general statement of legislative purpose to provide medical assistance "as far as practicable" under state conditions (Pet. 10), has ever been held to excuse a state's compliance with mandatory federal requirements.[10] Contrary to Petitioner's assertion (Pet. 10), the Medicaid Act provisions that require state payment of Medicare cost-sharing are in no way related to a state's authority to set Medicaid rates for covered Medicaid services. No latitude whatsoever is granted with respect to the former.

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10. *E.g., West Virginia Univ. Hosp. v. Casey*, 885 F.2d 11, 23-24 (3d Cir. 1989) ("budgetary constraints . . . [cannot] excuse a failure to conform to" federal standards), *aff'd*, 496 U.S. 936 (1990); *AMISUB (PSL), Inc. v. Colorado Dept. of Social Services*, 879 F.2d 789, 800 (10th Cir. 1989) ("budgetary constraints cannot excuse noncompliance with federal Medicaid law"), *cert. denied*, 496 U.S. 935 (1990).

CONCLUSION

For all of the foregoing reasons, Respondents New York City Health and Hospitals Corporation, Medical Society of the State of New York, Finkel and Bleski respectfully submit that the Petition for a Writ of Certiorari should be denied.

Dated: New York, New York
September 18, 1992

Respectfully submitted,

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RELEVANT STATUTES

42 U.S.C. §1396a(a)(10)(E)(i) provides that a State Medicaid plan must provide

> "for making medical assistance available for medicare cost-sharing (as defined in section 1396d(p)(3) of this title) for qualified medicare beneficiaries described in section 1396d(p)(1) of this title."

42 U.S.C. §1396d(p)(3) provides in relevant part:

> "The term 'medicare cost-sharing' means the following costs incurred with respect to a qualified medicare beneficiary without regard to whether the costs incurred were for items and services for which medical assistance is otherwise available under the plan:
>
> (A)(i) premiums under section 1395i-2 or 1395i-2a of this title and
>
> (ii) premiums under section 1395r of this title,
>
> (B) Coinsurance under subchapter XVIII of this chapter (including coinsurance described in section 1395e of this title).
>
> (C) Deductibles established under subchapter XVIII of this chapter (including those described in section 1395e and section 1395l(b) of this title).
>
> (D) The difference between the amount that is paid under section 1395l(a) of this title and the amount that would be paid under such section if any reference to '80 percent' therein were deemed a reference to '100 percent'."

No. 92-315

(3)

Supreme Court, U.S.
FILED
OCT 21 1992
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In the Supreme Court of the United States

OCTOBER TERM, 1992

CESAR A. PERALES, COMMISSIONER, NEW YORK STATE SOCIAL SERVICES, PETITIONER

v.

NEW YORK CITY HEALTH AND HOSPITALS CORPORATION, ET AL.

ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SECOND CIRCUIT

BRIEF FOR THE FEDERAL RESPONDENT IN OPPOSITION

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[BEST AVAILABLE COPY]

QUESTION PRESENTED

Whether, in the case of needy patients who have been enrolled by the State in Part B of the Medicare Program, a State may limit the reimbursement paid to doctors and hospitals to the amount covered by Medicaid.

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In the Supreme Court of the United States

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CESAR A. PERALES, COMMISSIONER, NEW YORK STATE SOCIAL SERVICES, PETITIONER

v.

NEW YORK CITY HEALTH AND HOSPITALS CORPORATION, ET AL.

ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE FIRST CIRCUIT

BRIEF FOR THE FEDERAL RESPONDENT IN OPPOSITION

OPINIONS BELOW

The opinion of the court of appeals (Pet. App. 1a-34a) is reported at 954 F.2d 854. The opinion of the district court (Pet. App. 35a-48a) is unreported.

JURISDICTION

The judgment of the court of appeals was entered on February 3, 1992. A petition for rehearing was denied on May 20, 1992. The petition for a writ of certiorari was filed on August 18, 1992. The jurisdiction of this Court is invoked under 28 U.S.C. 1254(1).

STATEMENT

1. Persons who are at least 65 years old or disabled and also meet other eligibility requirements are automatically enrolled in Part A of the Medicare program, a hospital insurance plan. Persons who are covered by Medicare Part A (and certain other persons) may purchase supplementary insurance for certain other medical services under Part B of the Medicare program by paying premiums to the Supplementary Medical Insurance Trust Fund. Under Medicare Part B, the federal government generally pays 80% of the "reasonable charges" for covered services. The patients are responsible for an annual deductible and the remaining 20% (the coinsurance). See Pet. App. 4a; 42 U.S.C. 1395*l*(a)(1), 1395*l*(b), 1395cc(a)(2)(A).

Medicaid is a need-based program funded by the federal and state governments; the federal government always pays at least half of the cost of the program. Under Medicaid, doctors and hospitals receive a specified sum set by the State for covered services, which is almost always less than the "reasonable charge" for the services under Medicare. Doctors and hospitals must accept the Medicaid sum as payment in full, and may not seek to recover from patients the difference between the Medicaid payment and their "reasonable charges" for purposes of Medicare. See Pet. App. 4a-5a; 42 U.S.C. 1320a-7b(d).

Some persons (such as elderly poor persons) are entitled to coverage under both Medicaid and Medicare Part A. Congress has provided that States may enroll those "dual eligibles" in Medicare Part B by paying the insurance premiums on their behalf.

See Pet. App. 5a; 42 U.S.C. 1395v. In addition, Congress in 1988 mandated that States participating in the Medicaid program purchase Medicare Part B coverage for certain other needy persons; those persons are called "qualified Medicare beneficiaries" or "QMBs." See Pet. App. 7a; Medicare Catastrophic Coverage Act of 1988, Pub. L. No. 100-360, § 301(a)(1), 102 Stat. 748.

At issue in this case is how much doctors and hospitals will receive for medical services rendered to dual eligible patients and QMBs when (as is usually the case) the amount payable under Medicaid is less than the "reasonable charges" for the service under Medicare. For example, the Medicaid fee for a service might be $50 although the "reasonable charge" for the same service under Medicare is $60. If a State did not enroll a dual eligible patient in Medicare Part B, it would pay $50 (the Medicaid fee) to the service provider, who would be barred from obtaining additional reimbursement from the patient. If the State enrolled the dual eligible patient in Medicare Part B, the federal government would pay $48 (80% of $60, the "reasonable charge" under Medicare) to the service provider. Under the New York regulation that is at issue in this case, N.Y. Comp. Codes R. & Regs. tit. 18, § 370-7.7 (1990) (*reprinted in* Pet. App. 50a-53a), which was approved by the Health Care Financing Administration (HCFA) in the Department of Health and Human Services, New York would pay an additional $2 to the service provider, who would be barred from seeking to collect any additional amount from the patient. Thus, under New York's regulation the service provider would receive a total of $50 (the Medicaid fee) for the service. If the dual eligible

patient were a regular Medicare Part B participant, the federal government would pay the service provider $48 and the service provider could seek to collect an additional $12 from the participant, for a total of $60 (the "reasonable charge" under Medicare). Prior to the adoption of § 370-7.7 in 1987, the State would have paid $12 on behalf of the dual eligible patient in addition to the federal government's payment of $48. Thus, before 1987, service providers in New York would have received $60, rather than $50, for the service. See Pet. App. 6a-7a.

2. The plaintiffs—a provider of hospital services, a physicians' association, and individual physicians who treat Medicare and Medicaid patients—brought this lawsuit claiming that the regulation New York adopted in 1987 is contrary to the Medicare and Medicaid provisions of the Social Security Act, 42 U.S.C. 301 *et seq.* The district court dismissed the action, holding that the Secretary's approval of the New York regulation reflected a permissible construction of the Social Security Act and was therefore entitled to deference under *Chevron U.S.A. Inc.* v. *NRDC, Inc.*, 467 U.S. 837, 842-844 (1984). Pet. App. 35a-48a.

3. A divided panel of the Second Circuit reversed. Pet. App. 1a-34a. It held that the New York regulation conflicts with the Medicare program's provisions for hospitals and doctors to be paid 100% of their "reasonable charges." *Id.* at 9a. The court explained that 42 U.S.C. 1395cc(a)(2)(A) expressly provides that a health care provider "may charge" a Medicare Part B patient "an amount equal to 20 per centum of the reasonable charges for such items and services * * * for which payment is made under [this subchapter]."

The court noted that the statute contains no exception for dual eligible patients or QMBs. Pet. App. 9a, 10a.

The court of appeals rejected the argument of the Secretary of Health and Human Services that dual eligible patients and QMBs are primarily Medicaid patients, so that service providers should be compensated at the Medicaid rate rather than the Medicare Part B rate. The Secretary's argument was based on the fact that those patients are enrolled in Medicare Part B by the State because they are needy. In response to the Secretary's argument, the court noted that the federal government reimburses doctors and hospitals for services provided to dual eligible patients and QMBs at 80% of the Medicare rate rather than the Medicaid rate. Pet. App. 10a. The court added that health care providers may treat uncollected Medicare cost-sharing amounts, including those from dual eligible patients and QMBs, as bad-debt expenses, which, in its view, supports the conclusion that dual eligible patients and QMBs are primarily Medicare Part B patients rather than Medicaid patients. *Ibid.* The court also pointed out that the legislative history of the Medicare provisions of the Act indicates that Congress sought to avoid a two-tiered health care system for the elderly by seeing that providers receive adequate payment, and concluded that denying service providers recovery of their full Medicare rate would undermine that purpose by discouraging doctors and hospitals from treating dual eligible patients and QMBs. *Id.* at 11a.

The court also found support for its holding in the Medicaid provisions of the Social Security Act. Under Medicaid, a state plan must make funds

available for "medicare cost sharing" for QMBs (42 U.S.C. 1396a(a)(10)(E)), and "medicare cost sharing" is defined to include Medicare Part B premiums, coinsurance, and deductibles (42 U.S.C. 1396d(p)(3)). Pet. App. 11a-12a. The court rejected the Secretary's argument that 42 U.S.C. 1396a(n), which *permits* a state Medicaid plan to provide for more assistance to QMBs than would be available under Medicaid, would be a nullity if the other provisions were interpreted to *require* the States to furnish payment of 100% of all reasonable charges. The court believed that Section 1396a(n) merely clarifies that a service provider will not be penalized for accepting more than the Medicaid amount. Pet. App. 12a-13a.

The court refused to credit legislative history accompanying a 1989 amendment to the Medicare program that recognized that some States (like New York, following promulgation of the 1987 regulation at issue) do not reimburse for reasonable charges in excess of 80% of the Medicare Part B rate, to the extent the excess would be beyond the fee payable under Medicaid. Pet. App. 15a-16a. In addition, the court concluded that the Secretary's position was not entitled to deference because the Department had stated in 1981 that a service provider could seek reimbursement for the 20% coinsurance payment from a Medicaid patient enrolled by the State in Medicare Part B. *Id.* at 18a.

Judge Cardamone dissented. He stressed that nothing in the Medicare or Medicaid provisions of the Social Security Act speaks directly to whether dual eligible patients and QMBs should be treated primarily as Medicare or Medicaid patients. Pet. App. 21a-23a. In that circumstance, he would have deferred

to the Secretary's construction of the complex statutory scheme. *Id.* at 34a. With respect to the apparent change in position of the Department of Health and Human Services, Judge Cardamone noted that a district court decision, *Samuel* v. *California Dep't of Health Services*, 570 F. Supp. 566 (N.D. Cal. 1983), had intervened and supplied a reasoned basis for HHS's new position. Pet. App. 31a-32a.

ARGUMENT

In our view, the court of appeals reached the wrong result in this case. But we do not think that the question presented warrants review by this Court at this time.

As this Court has recognized, "[t]he Social Security Act is among the most intricate ever drafted by Congress." *Schweiker* v. *Gray Panthers*, 453 U.S. 34, 43 (1981). The dissenting judge correctly pointed out that the Act's provisions do not clearly state whether dual eligible patients and QMBs should be treated primarily as Medicaid patients or as Medicare Part B patients. In that setting, the Secretary of Health and Human Services reasonably construed the Act to allow the regulation New York adopted in 1987. That regulation is premised on the view that dual eligible patients and QMBs are primarily Medicaid patients, a view that is entirely reasonable in light of the fact that they are enrolled by the State in Medicare Part B only because they are needy. In other words, it makes sense to look to the Medicaid statute in determining the government's obligations on behalf of needy patients.

Moreover, Congress ratified the Secretary's construction of the Act in 1989. At that time, Congress

enacted 42 U.S.C. 1395w-4(g)(3)(A) (Supp. II 1990), which provides that "[p]ayment for physicians' services" to dual eligible patients and QMBs "may only be made on an assignment-related basis." Congress explained that because "the Medicaid rules that result in assignment being accepted for all dual eligibles are not applicable to qualified Medicare beneficiaries * * *, physicians are able to bill these patients directly and to charge amounts in excess of what Medicare determines to be reasonable and what Medicaid will reimburse." H.R. Rep. No. 247, 101st Cong., 1st Sess. 364 (1989). At the same time, Congress recognized that state Medicaid programs "typically pay the Medicare coinsurance only to the extent that their payment, plus the Medicare payment, does not exceed what the Medicaid program would pay for the service." *Ibid.* Congress specifically stated that the amendment "*codifies* the current practice with respect to dual eligibles and extends it to qualified Medicare beneficiaries." *Ibid.* (emphasis added).

Finally, the Secretary's construction of the regulation works no unfair hardship on doctors and hospitals. Under the New York regulation at issue, they always receive the Medicaid fee for treating a needy patient. Sometimes—if 80% of the "reasonable charges" under Medicare Part B exceeds the Medicaid fee—they receive more than they would if the State had not enrolled the patient in Medicare Part B.

Nevertheless, we cannot say that this case warrants review by the Court at this time. The difference between the Medicaid fees for various services and the "reasonable charges" under Medicare Part B adds up to a substantial sum (see Pet. 7 &

n.4), more than half of which is paid by the federal government. But that sum still represents only a fraction of the total cost of the Medicaid program. In our view, the question presented would unquestionably be worthy of review by this Court if there were a conflict in the circuits. This case, however, represents the first time this complex issue of statutory construction has been decided by a court of appeals—indeed, by any court.* As petitioner notes (Pet. 11 n.6), other cases are already pending presenting the same question. We believe it would be appropriate to await further litigation developments before this Court addresses the issue.

CONCLUSION

The petition for a writ of certiorari should be denied.

Respectfully submitted.

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* Petitioner suggests (Pet. 8) that this case is comparable to *Simon & Schuster, Inc.* v. *Members of the New York State Crime Victims Bd.*, 112 S. Ct. 501, 508-509 (1991), and therefore warrants immediate review. But that case involved what was in effect a prior restraint on First Amendment activity.